Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

Best Care. Right Place. Right Time.
2012-2013 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Vision, Mandate, Mission and Values

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need access to local health services.

To achieve this we are committed to:
Transparency; Collaboration; Innovation; Real Conversation

Message from the CEO and Chair

We once heard Deb Matthews, the Minister of Health and Long-Term Care, compare the health care system to a relay race. Team members may run as fast as they can, but the real success of the race hinges on one very important aspect – successfully handing off the baton to the next team member. Health care providers (team members) are providing the best care they can, and as a system, we need to do better at transitioning patients (the baton) between providers.

We know that the current health care system has to work better for citizens today and be better positioned to care for citizens tomorrow. We must turn the health care system on its head, shifting the focus from providers to the **person.**

That's why, this year, we undertook *ACTION: A Call To IntegratiOn Now*. This process involved the collaboration and collective ideas of many, including more than 2,000 local citizens, health service providers and stakeholders. This work led to the development of our Strategic Health System Plan (SHSP) which, over the next five years, will take us on a journey to a new health care system that dramatically improves the patient experience through quality, integration and value.

While we know there is a still lot of work to do, we have made significant steps in the right direction.

Last year:

- We enhanced access to home and community services thanks to a $15.1 million investment in new and expanded programs and services. This investment supports seniors and other individuals to receive services closer to home, reduce emergency department wait times, improve alternate level of care (ALC) rates, reduce avoidable hospital admissions, and most importantly, help people get the best care, in the right place, at the right time.
- We made great strides in improving care for older persons with responsive behaviours through the Behavioural Supports Ontario (BSO) project. We implemented five outreach teams to provide just-in-time care to individuals and their caregivers in the community and established long-term care home mobile teams to build capacity in the homes to help them manage individuals with responsive behaviours. These individuals and their caregivers now experience more coordinated care and better transitions across sectors and providers.
- We cut our internally monitored ALC rate nearly in half to 12.5% in October 2012 from 25% in July 2009. This means that more people received the care they needed, in the right place, at the right time.
- We reduced the number of people waiting in hospital for long-term care by 60% from 360 in August 2010 to 143 in August 2012.
- People waited less time for MRI and CT scans as we surpassed our 2011-12 targets for these indicators. We reduced the wait time for MRI scans to 63 days in November 2012 from 119 days in April 2011. We reduced the wait time for CT scans to 37 days in November 2012 from 43 days in April 2011.

We are certainly proud of the achievements of health providers across the LHIN, not only because of their outcomes for the people we serve, but also because they demonstrate what is possible when we – the LHIN, health service providers, citizens and stakeholders – **work together with a common vision.**

On behalf of the staff and the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we sincerely thank each and every one of our partners for your dedication to improving the health care experience for the citizens of our communities.

We also acknowledge and are immensely grateful for the efforts of our staff and Board whose expertise and passion continue to drive us forward.

We look forward to continuing on our journey together to create a health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Sincerely,

Donna Cripps
Chief Executive Officer

Michael Shea
Board Chair

The HNHB LHIN Board of Directors

Left to right back row: Mervin Witter, Bob Lawler, Michael Shea
Second row: Laurie Ryan-Hill, Ruby Jacobs
Front row: Helen Mulligan.

Michael Shea, Chair

Appointed: October 28, 2010 • Term: 3 years
Appointed Chair: June 2, 2011 • Term: 3 years

Bob Lawler, Vice Chair

Appointed: October 29, 2008 • Term: 3 years
Appointed Vice Chair: June 2, 2011 • Term: 3 years
Re-appointed: November 30, 2011 • Term: 3 years

Ruby Jacobs, Member

Appointed: March 3, 2010 • Term: 3 years
Re-appointed: March 20, 2013 • Term: 3 years

Helen Mulligan, Member

Appointed: June 17, 2010 • Term: 3 years

Laurie Ryan-Hill

Appointed: May 17, 2011 • Term: 3 years

Mervin Witter, Member

Appointed: June 2, 2011 • Term: 3 years

Transitions in Board Membership

After serving as a Board member since June 2011, the Board wished Nathalie Brown well in her future endeavors, as she moved on to an exciting new career opportunity on February 12, 2012.

In December 2012, the Board approved the motion to *initiate the recruitment process immediately for one Board Member for submission to the Public Appointment Secretariat for approval and posting, with a plan for the staggered appointment for the remaining two vacant positions.*

Relationship Between the Board and Leadership Team

As of April 1, 2012, the LHIN Leadership Team included the CEO and Directors of Communications and Corporate Services, Health System Transformation, Access to Care, Quality and Risk Management, Finance, and Physician Lead, Clinical Health System Transformation.

Leadership Team members attend the regular Board business and education meetings and present monthly verbal and written reports to the Board on the activities in their respective portfolios. Led by the CEO, the Leadership Team guides strategic operations of the organization.

The Board provides ongoing direction to the CEO through:

- Regular business and education meetings.
- Board committees.
- Policy direction.
- Performance appraisal.

The HNHB LHIN consistently engages its health service providers and community members in active discussions in order to continue to dramatically improve the health care journey for all residences within its borders.

Continued Evolution of the HNHB LHIN

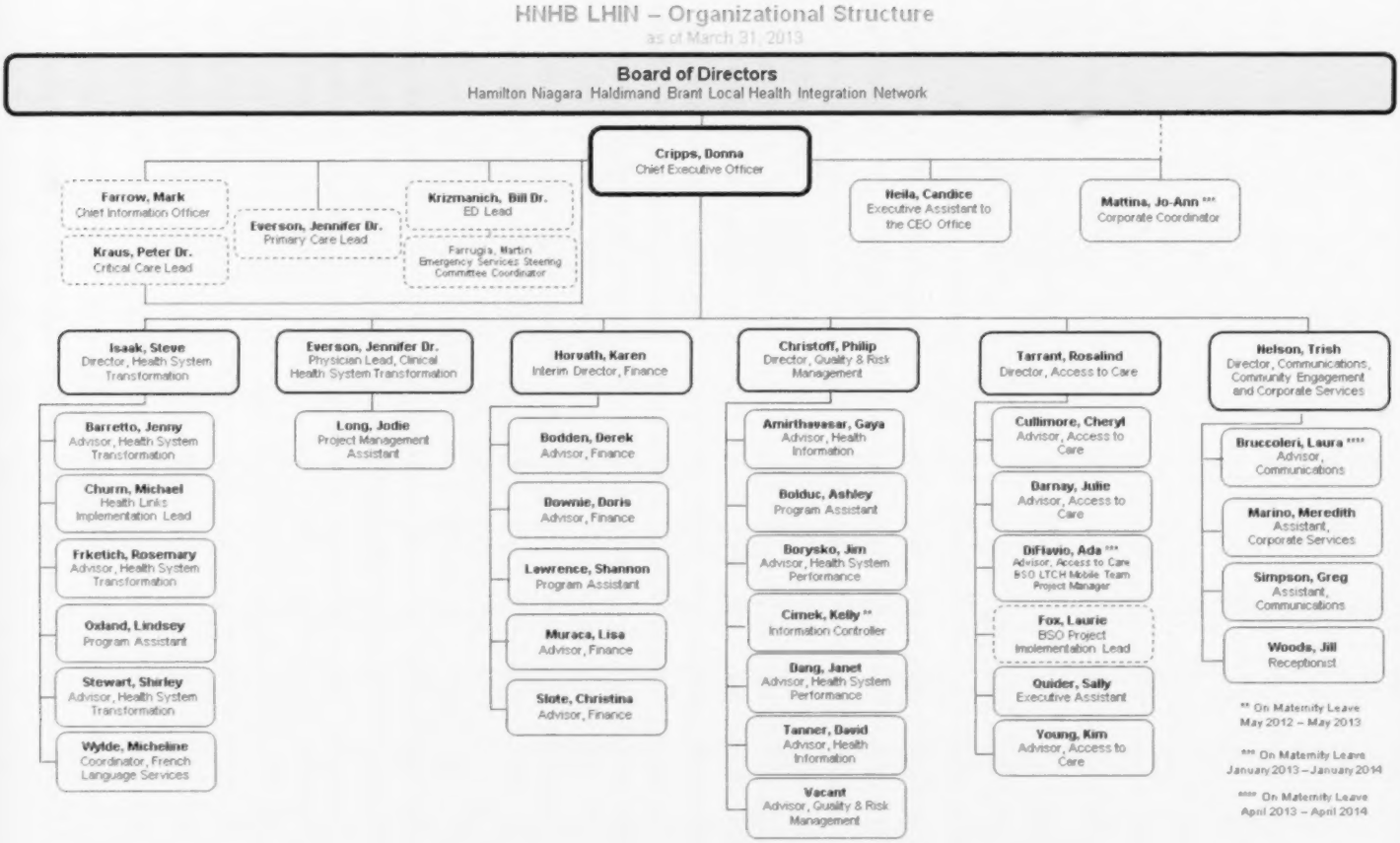
Our Organization

Staff

HNHB LHIN staff is committed to and passionate about working toward achieving the LHIN vision - a health care system that helps keep people healthy, gets them good care when they're sick, and will be there for our children and grandchildren. It is this vision that guides them in carrying out the duties of their roles.

The structure of roles within the organization is based on the core functions of the LHIN and maximizes the skills, knowledge and expertise of staff. Staff remains committed to building capacity and sharing knowledge through further training and education, and participation in local, provincial, and national activities.

Staff is guided by the values and principles of the organization including respect, integrity and accountability and to achieve this staff is committed to transparency, collaboration, innovation and real conversations.



Snapshot of the HNHB LHIN

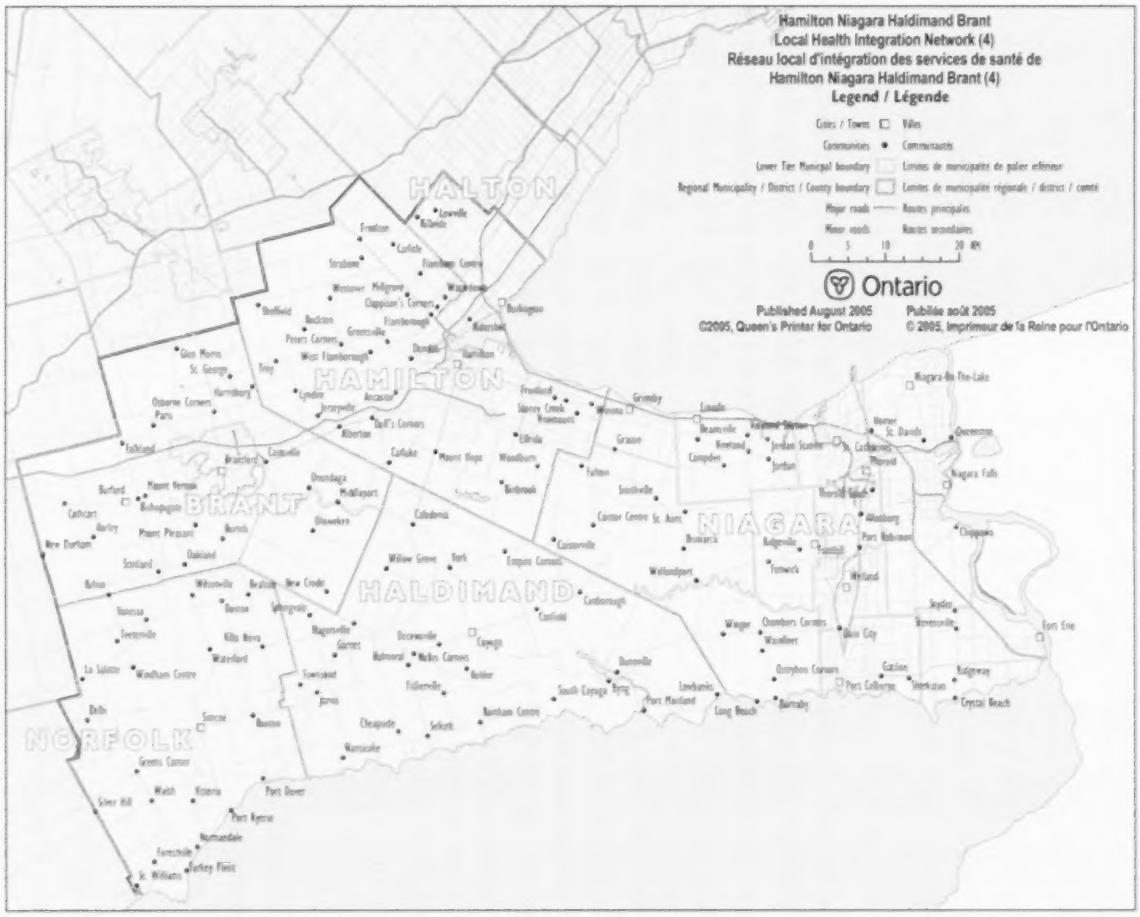
HNHB LHIN Population

Demographics

The HNHB LHIN is home to approximately 1.42 million people or 10.6% of the population of Ontario. The LHIN population is projected to grow 4.2% over the next five years and 8.9% over the next 10 years *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

The LHIN's population is aging. The total number of people 65-74 years old is growing the fastest and the largest changes will be among people age 60 to 79 over the next 10 years.

As of 2012, nearly 240,000 people age 65 or older live in the LHIN which is the largest number of seniors of all Ontario LHINs *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*



Socio Demographic Characteristics

The LHIN has a diverse population. For 18% of residents, neither English nor French is their first language. Francophone, First Nations, and urban and rural Aboriginal people are recognized populations in the LHIN. Compared to Ontario, the LHIN has a lower percent of immigrants and visible minorities.

There are two reserves in the LHIN – Six Nations of the Grand River Territory, which has the largest population of all First Nation communities in Canada, and Mississaugas of the New Credit First Nation. The total registered Aboriginal population in the LHIN is approximately 24,000 people (1.7% of the total LHIN population) with about half the population living on reserve. Non-Status, Métis, and Inuit populations are not included in these population estimates *(Source: First Nations Peoples in Ontario: A Demographic Portrait. Ministry of Health and Long-Term Care, Health System Information Management and Investment Division. Health Analytics Branch, January 2009).*

The LHIN has a higher percent of lone parent families and a lower percent of adults with post-secondary education than the Ontario average.

	HNHB LHIN	**Ontario**
Total Population (2012)*	1,417,928	13,372,999
Senior population, age 65+ (2012)*	16.3%	14.2%
Population with English mother tongue	80.1%	69.8%
Population with French mother tongue	2.2%	4.8%
Population who are immigrants	20.3%	28.3%
Population who are recent immigrants (arrived between 2001-06)	2.3%	4.8%
Populations who are visible minorities	9.1%	22.8%
Population of Aboriginal identity	1.7%	2.0%
Labour force participation rate (age 15+)	65.7%	67.1%
Unemployment rate (age 15+)	6.0%	6.4%
Population in low income (before tax) all persons	13.7%	14.7%
Families (with children) headed by a lone parent	16.2%	16.0%
Population (age 25-64) without certificate, degree, Diploma	14.6%	13.5%
Population (age 25-64) with completed postsecondary Education	57.9%	61.4%

Sources: *Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO. *Remaining indicators based on 2006 Census of Canada, Statistics Canada.*

Health Status

Self-reported health can show aspects of health not captured in other measures. Similar to Ontario's rates, more than 61.5% of LHIN residents rate their health as 'excellent' or 'very good' *(Source: Statistics Canada, Canadian Community Health Survey, 2009-10).* However, significantly more LHIN residents say they are limited in activities because of a physical or mental condition or health problem and have pain or discomfort that prevents them from engaging in activities.

Illness, Disease and Death

The LHIN's residents have significantly more arthritis/rheumatism compared to the province as a whole. Rates of asthma and high blood pressure are slightly but not significantly higher than Ontario rates. Diabetes rates, on the other hand, are comparable to the province *(Source: Statistics Canada, Canadian Community Health Survey, 2009-10).*

Death rates reflect the overall health of the population Heart disease, lung cancer, and stroke were the top three leading causes of death.Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e., before age 75). Deaths, potential years of life lost and hospitalization rates in the
LHIN are higher than provincial rates.[1]

Health Practices and Preventive Care

Poor health practices such as physical inactivity or poor dietary habits may increase the risk of chronic disease, disability, and death. Relative to the province, more people in the LHIN smoke daily or occasionally, drink heavily, and are obese.[2]

Preventive health care services such as good hand hygiene practices or regular health screenings can help find disease early, which over the long term reduces illness and death. Of the selected preventive health indicators, none are significantly different from Ontario as a whole. Among women in the LHIN, 71.7% had a Pap smear (for cervical cancer screening) within the previous three years, 73.1% received a routine mammogram in the previous two years, and 31.7% had a flu shot in the past year.[3]

Most people get their care through their family doctors. Doctors also play a key role in coordinating care and managing chronic conditions. The majority of HNHB LHIN residents (79%, this excludes patients who receive their care from a CHC or other primary care services from a family doctor) are enrolled with a family physician. This is higher than the Ontario rate (73%).[4]

Summary

The LHIN covers approximately 6,500 km^2, encompassing Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk. With approximately 1.42 million people, it includes small rural communities and large urban centres, with a population that is culturally and linguistically diverse.

Relative to Ontario, the LHIN has a higher percent of:

- Lone parent families.
- People limited in their daily activities.
- Daily or occasional smokers.
- People who drink heavily.
- People who are obese.
- People with arthritis/rheumatism.

The LHIN also has:

- The most seniors of any Ontario LHIN.

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[1] Death, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.
[2] Statistics Canada, Canadian Community Health Survey, 2009-10.
[3] Statistics Canada, Canadian Community Health Survey, 2005, 2008 and 2009-10.
[4] Health Analytics Branch, Feb 2012.

- A higher rate of premature death and hospitalization.
- A lower percent of adults with post-secondary education.

Engaging our Communities

Community engagement is a core function of the LHINs. This function is written into the *Local Health System Integration Act (LHSIA)*, 2006 which created LHINs. As part of its work, the LHIN engages a diverse range of people, including residents, health professionals, and those who are actively involved in the health system. This includes engaging with Aboriginal, First Nations and Francophone communities. The LHIN recognizes, respects, and seeks to understand and address the unique needs of its diverse communities.

Aboriginal Health Engagement

LHINs are mandated to work with Aboriginal communities for improved health and wellness. The LHIN has a responsibility to learn about and respect Aboriginal communities' approach to health and wellness and how this approach guides the identification of health needs and solutions. Respect for and inclusion of Aboriginal traditional practices with non-traditional health providers is essential for health solutions aligned with cultural identity, holistic health, and community values.

The HNHB LHIN's Aboriginal Health Network (AHN) provides Aboriginal health and social service providers the opportunity to collaborate with the LHIN to address the health needs and issues of the Aboriginal communities. The AHN meets monthly and includes representation from Aboriginal health and social services organizations from across the LHIN.

The Aboriginal Health Network held a three-day retreat in January 2012 and identified three key priorities for their three-year action plan, including:

- Reduce youth suicide and strengthen services to support youth's mental health.
- Reduce the Aboriginal rate of diabetes and other chronic conditions.
- Reduce domestic violence and support strong, stable, responsible families.

To support these priorities the Aboriginal Health Network engaged in the following activities during the 2012-13 fiscal year:

- LHIN one-time funding enabled the Canadian Mental Health Association to partner with Six Nations and provide suicide prevention train-the-trainer sessions in both ASIST and safeTALK programs for off-reserve Aboriginal organizations across the HNHB LHIN.
- LHIN one-time funding enabled De dwa da dehs nye's Aboriginal Health Centre to provide five cultural awareness training sessions for mainstream health service providers across the HNHB LHIN. The sessions were the first steps toward building cultural sensitivity, competency and safety in cross-cultural environments by helping health service providers think strategically about the needs of various populations, and to work together to improve the delivery of services to these populations.
- The LHIN Aboriginal Engagement Fund enabled a full-day Aboriginal Health Workshop, where Aboriginal health service providers and the broader Aboriginal community discussed current and future Aboriginal patient health care journeys.

- The discussions aimed to:
    - Incorporate culturally appropriate Aboriginal health service planning throughout the implementation of the HNHB LHIN Strategic Health System Plan.
    - Build upon the health services and programs already being led by Aboriginal health care and mainstream providers to dramatically improve the Aboriginal patient experience through quality, integration and value to improve Aboriginal population health throughout the HNHB LHIN area.

The Aboriginal Health Network will be utilizing the information and recommendations from the Aboriginal Health Workshop to develop concrete action plans for the next year.

In addition to the outlined work of the Network, members and community members took part in engagement sessions related to the HNHB LHIN's Strategic Health System Plan. The Aboriginal Peoples Reference Panel was instrumental in ensuring the voice of Aboriginal peoples was part of the LHIN-wide engagement.

Francophone Health Engagement

The *French Language Services Act (FLSA), Ontario, 1986*, recognizes the contribution of the French speaking population to the historical, cultural, and linguistic heritage of Ontario. The *FLSA* guarantees the right of French speaking Ontarians to communicate with the government and receive services in French. To this end, the LHINs plan and promote French language health services, and engage the French speaking community in the process. French speaking residents and stakeholders know their communities best and the goal is to ensure the best outcomes for French language health services, acknowledging and respecting diversity within Francophone communities.

Partners in Health

The HNHB LHIN, Waterloo Wellington LHIN, and the *Entité de planification pour les services en français dans les régions de Waterloo, Wellington, Hamilton, Niagara, (FLPE)* signed a five-year funding and accountability agreement starting April 1, 2011. The agreement sets out the roles and responsibilities of each party related to the provision of advice by the FLPE on:

- Methods of engaging its Francophone community.
- The health needs and priorities of its Francophone community, including the needs and priorities of diverse groups within that community.
- The health services available to its Francophone community.
- The identification and designation of health service providers (HSPs) for the provision of French language health services in the HNHB LHIN.
- Strategies to improve access to, accessibility of, and integration of French language health services in the local health system.
- The planning for, and integration of, health services in French in the HNHB LHIN.

The accountability agreement required the establishment of a Joint Liaison Committee (JLC) whose role is to develop appropriate mechanisms for ongoing dialogue and collaboration and a yearly Joint Annual Action Plan (JAAP) that sets out the objectives, priorities and actions each party will undertake in the current fiscal year.

The HNHB LHIN is the lead LHIN responsible for the provision of funding under the agreement.

Francophone Community Engagement

As part of the development of the Strategic Health System Plan (SHSP), the FLPE and the HNHB LHIN engaged a group of francophone individuals, members of a Francophone citizen's reference panel (FCRP), whose task was similar to that of the larger general Citizen's Reference Panel (CRP), and like the larger group, stressed the need for, amongst other things:

- Improved coordination of services and the option of having a "pivot person" that can help client navigate the system.
- Improved access to primary care and having alternate choices of services.
- Offering services in the primary language of the patient, particularly when they are in vulnerable position (i.e. Emergency Department (ED)).

Listening and Learning

The LHIN engages health service providers is to increase knowledge and awareness of FLS in order to improve access to quality health services in French and to assist them in planning and implementing FLS for their Francophone clients.

As a result of this on-going work:

- 96% of FLS-identified HSPs have submitted an FLS Implementation Plan (FLSIP) describing how the HSP plans to improve access to services in French, which includes engagement with the francophone community to determine priority needs.
- At the end of the 2012-13 year, 71% of FLS-identified health service providers reported an increase in the number of francophone clients served and 46% of FLS-identified agencies reported that they are serving more Francophone clients in French.

Stakeholder Engagement - ACTION (A Call To IntegratiOn Now) – Our Strategic Health System Plan (SHSP)

As part of its strategic planning process, the HNHB LHIN pioneered new ground in order to put people at the heart of quality health care. The LHIN engaged citizens from across its communities for their insights, experiences and ideas to help transform the local health system. Individuals will experience care that is coordinated, of the highest quality, is fiscally responsible, and results in better outcomes for people.

By leveraging the knowledge and experiences of citizens throughout its communities over a six-month period, the LHIN better understands the current state of health service delivery. Throughout this process, the LHIN's goals were to understand what is working well, what can be improved upon and what integration opportunities exist with health service providers.

More than 2,000 stakeholders were engaged during ACTION:

- Steering Committee
- Citizens' Reference Panel (CRP)
- Francophone CRP
- Aboriginal Peoples Panel
- Two online surveys open to public
- Provider Working Group
- Physician Leads Group
- Provider Networks
- Survey to health care providers
- Focus groups with consumers and provider experts on priority populations: seniors, mental health and addictions, new immigrants and chronic disease

Communications and engagement initiatives supporting this strategic planning process began in March 2012 and continued through November 2012. During this time, the LHIN broadly reached citizens through

website postings and forums, proactive media relations, social media activities, and other communication tactics.

In addition to the activities and tactics listed above, a large component of the LHIN's efforts centered on engaging citizens for their input and feedback. This was achieved through consultation and working sessions with volunteer representatives from across all communities.

Though health care needs within the LHIN vary, dialogue with citizens uncovered several improvement themes, including:

- **Focus on the person** - respectful communication; appropriate and accessible information to suit all populations.
- **Focus on prevention and education** - increase health promotion, prevention and education programs.
- **Shift services and resources (as appropriate)** - out of the hospital and into the community, closer to home.
- **Demonstrate specialized community-based care for highest risk populations** using a "health coordinator," "care navigator" or "pivot person."
- **Improve value for money** - address inefficiencies leading to increased wait times, evaluate ongoing treatments/tests/procedures, access general care at the least expensive provider level, optimize administration and decrease administrative costs, review salaries of top administrators, and make funding (and salaries) contingent on outcomes.

These themes were reviewed and assessed, along with input and feedback received from other stakeholders – all of which have helped form the framework for the future health system.

As the SHSP was being develop and again when it was being finalized, LHIN staff including the CEO and LHIN board members including the Chair met with and held online webinar sessions for elected officials throughout the LHIN including municipal, regional and provincial representations and administrative leadership. These meetings were also an opportunity to keep political representatives informed of LHIN initiatives and activities, as well as to provide a forum for discussion about community health care needs, issues and concerns.

A final communications and engagement report was prepared and outlined the engagement activities and outcomes related to the ACTION work. It was made available to all participants and posted on the LHIN website. This report was one of the foundational documents in the development of the final five-year SHSP.

Physician Engagement

HNHB LHIN staff continues to develop a variety of physician networks. The Chief Medical Leaders (CML) group continues to meet monthly and work on their annual deliverables. In 2012-2013, the CML focused on improving transfers from small hospitals to the larger community and academic hospitals by developing a formal buddy system that allowed better communication and coordination of patients that currently do not fit within the regional program structure, or the life and limb strategy. This group received regular updates from the various physician networks and continues to have a significant role with clinical planning and integration, to improve standardization and reduce variation of clinical care across our LHIN. Once again, the Chief Medical Leads organized an education session for all the physicians in the LHIN, and the

Antibiotic Stewardship group continues to meet regularly. This group is comprised of the Chiefs of Staff or Vice President Medicals of all HNHB LHIN hospitals.

The Diagnostic Imaging (DI) Network worked collaboratively with their administrative leads to successfully reduce the Medical Resonance Imaging (MRI) and Computed Tomography (CT) wait times. The interventional DI checklist continues to be used and there is discussion at the provincial table for further roll-out. Together, this network all agreed that the focus for next year will be on clinical integration of interventional DI.

The Obstetrical Network joined the Southern Ontario Maternal Child Network to focus on developing concrete strategies to reduce the high Caesarean section (C-section) rate within this LHIN. The group has begun to review the data and the variation in definition of requirements for C-sections. This group will develop best practices to improve identified areas, including screening and C-section rates.

In February 2012, and with endorsement from the Ministry of Health and Long-Term Care, Primary Care Leads were introduced in each of the province's 14 LHINs to strengthen and further integrate primary care into health planning. Dr. Ross Male worked with the HNHB LHIN staff to develop a set of questions for family physicians to identify patients who are at risk of requiring an emergency room (ER). This frailty questionnaire has been tested across our LHIN in a variety of practice settings, and will be rolled out to all family physicians as Health Links become established. The HNHB LHIN's Physician Lead, Clinical Health System Transformation has now assumed the interim role of Primary Care Lead for the HNHB LHIN. The HNHB LHIN is actively implementing Health Links across our LHIN. The Primary Care Network will now include the physician leads from each of the Health Links, as well as membership from a variety of organizations, including the Ontario Medical Association (OMA), Ontario College of Family Physicians (OCFP), McMaster University, and the hospital-sector.

The Laboratory Medical Directors have been working on three quality projects, which include standardization of the reporting of critical values across our LHIN, and turn-around times for cardiac enzymes to improve patient flow within the emergency departments (EDs).

Physician engagement has been essential to the success of our clinical integration in Vascular, Thoracic, and Oncology. This will continue next year as other clinical areas are the focus of best practice, reducing variation, and improving access across this LHIN.

Working Together for Better Quality Care

System-wide Quality Improvement

Throughout the year, the LHIN engaged its HSPs and partners on advancing system-wide quality improvement. At the governance level, the LHIN and its providers (LHIN hospitals the Community Care Access Centre (CCAC)) came together to discuss the opportunities, partnerships and leadership required to advance quality improvement and health system transformation. The overall goal of the session was to share perspectives and discuss the key action steps required to develop a road map to system wide quality improvement. In 2012-13 the LHIN also worked with all providers across the continuum of care through a variety of networks, including: Clinical Vice Presidents, members of the Long-Term Care Home Network, and Executive Directors of Community Health Centres and mental health and addictions agencies.

Through this engagement, partners together advanced:

- A focus on the patient perspective.
- Fostering innovative ways of thinking.
- Sharing ideas and strategies.
- Using data to drive change and patient care.

Focusing on Quality and Safety

To determine key priorities to address safety, effectiveness, access and patient satisfaction, the HNHB LHIN Board reviewed the LHIN's progress across a number of indicators.

The Total Joint Replacement Working Group has created LHIN-wide standardized clinical care paths, order-sets, and patient education materials, which will be implemented by October 2013 to improve variation on length of stay, and reduce wait times.

Primary hip and knee replacement is important for the function and quality of life for many patients. Patients across the LHIN currently experience different processes when going to hospital for orthopaedic surgery. Consistent processes are proven to lead to better patient outcomes. The HNHB LHIN in partnership with Clinical Vice President group, Chief Medical Leaders, and Total Joint Replacement Working Group developed the Integrated Orthopaedic Capacity Plan (IOCP). The HNHB LHIN has set an aim to have all hospitals within the HNHB LHIN performing hip and knee replacement surgery within the acceptable performance range for wait times by March 31, 2014.

To ensure accurate waitlists to assess demand, the LHIN is working with hospitals to utilize current best practices, such as the use of Date Affecting Readiness to Treat, or patient care plans to reduce variation across the LHIN. The LHIN is working with hospitals to ensure that best practices in one hospital are shared with others. Our wait times do vary significantly across our hospitals and learning how to best manage patient care is a shared responsibility.

The LHIN will also be working with hospitals by putting specific requirements into their Hospital Service Accountability Agreements (HSAAs) with the LHIN to ensure that each and every hospital uses best practices to manage wait lists. It is important to make sure that we meet our targets and use all the tools available to achieve these ends.

Another area of focus for the HNHB LHIN is cataract wait times. Cataract volumes were reduced by 10% across the province in May 2012, this decrease in volumes was one of the contributors to an increase in wait times. In January 2013, the HNHB LHIN board approved one-time funding for additional cataract volumes to help address the LHIN's increased wait times.

The LHIN's Clinical Integration plan will address ophthalmology services and focus on cataract wait times. The HNHB LHIN has utilized data to facilitate discussion around reduction of wait times with health service providers. Following a March 2013 meeting with physicians, LHIN staff implemented weekly calls to monitor the implementation of improvement strategies.

Key components of quality improvement include monitoring key performance indicators and sharing best practices for safety. Data and information are vital enablers to advancing the LHIN's quality priority. As such, the LHIN along with HSPs continue to work to improve data availability, integrity, and utilization to make more informed decisions about care delivery, resulting in improved health care experiences for residents.

Sharing best practices, successes and ideas drive quality improvement. The LHIN has brought health service providers (HSPs) together to ensure that best practices inform decision-making and result in improvement for patients. Starting in April 1, 2011 hospitals across the province have created public Quality Improvement Plans (QIPs) as required by the *Excellent Care for All Act, 2010 ECFAA*. Community Health Centres will submit their first QIPs on April 1, 2013. The LHIN continues to engage hospitals, CCAC, but also, the community support services (CSS) sector as well as the Long-Term Care Homes (LTCHs) about quality improvement activities, best practices, staff engagement and strategies to better impact the patient experience. The LHIN continues to work with HSPs to set priorities consistent with system-wide goals and focus efforts on setting reasonable stretch targets to enhance patient safety and quality of care.

In 2012-13, the HNHB LHIN Board approved the strategy for implementing quality improvement across health service providers in the HNHB LHIN. The LHIN's strategic goals for quality improvement focus on advancing and supporting best-practices and building on areas requiring further development. Specifically, the HNHB LHIN will utilize its Service Accountability Agreement (SAAs) for quality improvement to solidify and advance quality goals and processes. This will build on existing quality improvement plans (QIPs) set out in the ECFAA. Each SAA will require health service providers to have in place the following:

- A Board approved policy on Quality Improvement;
- A balanced scorecard; and,
- A plan to track variances and outline strategies for improvement.

The LHIN Board approved an Enterprise Risk Management Framework to ensure that all key risks to achieving system-wide goals are identified, measured and mitigated wherever possible. Unlike risk management programs that focus only on insurance and liability, Enterprise Risk Management allows the organization to review all HSP-related and internal organizational risks and opportunities available to achieve organizational and system goals. Through this process, the Board and LHIN staff monitor and act on HSP-related risks to patients, finances, and quality of care. This program assists the LHIN in achieving its fiduciary responsibility of delivering better care, better value and better health.

At its March 2013 meeting the HNHB LHIN Board approved the Performance Accountability Strategy. The Strategy sets out a philosophy and framework for HNH BLHIN staff to identify, assess, control and communicate health service provider risks. The strategy's goal is to focus HNHB LHIN efforts in achieving the strategic direction of becoming a health system commissioner and also to set out clear action steps to work with health service providers to meet performance obligations.

Safety is paramount for patients. The LHIN has worked with health service providers to facilitate consistency and sharing of patient information as they transition from one care provider to another. Some examples of this work include the standardization of key quality initiatives in hospitals such as drug safety. These initiatives impact patient access, safety and costs. The LHIN continues to lead efforts with HSPs to identify key strategies to facilitate the smooth transfer of patients across the care continuum. This is reflected with work on standardized discharge procedures and medication reconciliation.

Senior Friendly Hospitals

LHINs across the province are leading a Senior Friendly Hospital Strategy– an initiative to improve seniors' health and prevent their physical and mental decline in hospital. By acting together, hospitals can improve the experience and outcomes of older adults in Ontario hospitals.

The Senior Friendly Hospital (SFH) strategy aims to:

- Improve the health, wellbeing and experience of seniors in Ontario hospitals, helping them get back home sooner and healthier.
- Improve seniors' ability to live independently and stay out of hospital.
- Enhance the value of health care dollars.
- Help reduce alternate level of care (ALC) through supporting people to transition to the right place of care after a hospital stay.
- Promote quality improvement initiatives that can be included in hospital Quality Improvement Plans (QIPs) as part of *Excellent Care for All Act, 2010* (ECFAA).

As a first step, each hospital assessed their successful seniors' initiatives, and identified opportunities for improvement and action. All adult hospitals in Ontario have completed a SFH assessment. Summary reports for each LHIN were developed in collaboration with the Regional Geriatric Programs of Ontario. The summary report for the LHIN, *A Summary of Senior Friendly Hospital Care in HNHB LHIN Hospitals*, is available at www.hnhblhin.on.ca.

In January 2012, the HNHB LHIN brought together representatives from each hospital to share key successes and challenges to date, as hospitals work towards SFH Action Plans, responding to the recommendations in the local and provincial Senior Friendly reports.

Health Professionals Advisory Committee (HPAC)

Since March 2008, HPAC members have played an important role in bringing insight from their respective sectors and perspectives to the LHIN. This committee focused on opportunities to optimize interprofessional care and scopes of practice within the LHIN.

HPAC has continued to work on implementing the five recommendations to enhance scope of practice across our LHIN. The five recommendations are:

- Recommendation #1 – Definition: The Health Professionals Advisory Committee adopt the definition of IPC in the May 2010 Final Report of the Interprofessional Care Strategic Implementation Committee, "Implementing Interprofessional Care in Ontario." Definition: Interprofessional Care is the provision of comprehensive health service to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.
- Recommendation #2 – The HPAC of the HNHB LHIN determines: a) An appropriate education session for health professionals on the Regulated Health Professionals Act and its relationship to IPC. The education session will use the principles of adult education and behaviour change theory; b) To create opportunities for discussion related to the issues surrounding liability, scope of practice and IPC.

- Recommendation #3 – The HPAC of the HNHB LHIN develops an understanding of the incentives to promote IPC and share knowledge with providers across the LHIN to encourage IPC development.
- Recommendation #4 – The HPAC will work with health education institutions to facilitate linkages that support the integration of IPC modeling with education placements in the LHIN.
- Recommendation #5 – The HNHB LHIN identifies an IPC Champion(s) in the LHIN to facilitate the advancement of IPC.

With the implementation of Health Links, this group will become an integral part of the Primary Care Network, as the importance of collaboration between allied health and primary care providers is critical.

Advancing Our Priorities

While 2012-13 represented the final year of the HNHB LHIN's second Integrated Health Service Plan (IHSP), it also represented a year to look ahead with the development and completion of the five-year Strategic Health System Plan (SHSP).

While all LHINs are required to develop a three-year IHSP, the HNHB LHIN also developed its five-year SHSP. While the two documents are separate and distinct, they work hand-in-hand. From the beginning, the LHIN was clear that this work would not result in a 'plan to plan' – this work would be outcome and results based and this was reflected in approach taken. ACTION (A Call To IntegratiOn Now) was the strategic planning process to identify those key directions which, taken together, will transform the local health system.

The intent of the Strategic Health System Plan is to build an evidence-based, integrated and person-centred health care system. This pursuit reflects the Institute for Healthcare Improvement's Triple Aim approach, which focuses on:

- The health care experience of the individual
- The health of a defined population
- The per capita cost for the population

The Strategic Health System Plan provides a roadmap to achieve HNHB's objectives: a local integrated health care system where care is coordinated, of the highest quality, cost effective, and results in better outcomes for the population.

Highlights of the Approach

A four-phased approach was used to support the development of an informed Strategic Health System Plan. The approach was designed with the following tenets:

- LHIN ownership and staff championship
- Board engagement
- Community engagement
- Building on work and engagement completed to date
- On-going internal and external communications

The Strategic Health System Plan was shaped by meaningful input from a broad array of stakeholders. Over the course of the Plan development, the process provided the LHIN Board, LHIN staff, providers, and

community members with multiple opportunities to share their perspective, comment on deliverables, and develop and validate recommendations.

The planning process enabled the development of an evidence-based and provider/community-informed Strategic Health System Plan. Findings from both quantitative and qualitative assessments provided the foundation for the current state and coupled with leading practice-based research served as the inputs into the development of the strategic directions and future state model found in the Strategic Health System Plan.

HNHB LHIN Board

The HNHN LHIN Board was fully and actively engaged and provided oversight and direction from the project's inception and throughout the development of the Plan. In early discussions and presentations to the Board staff was given clear and pointed direction to 'be bold in moving forward' with our ACTION work and the Strategic Health System Plan. At key milestones throughout the year, the Board was engaged to provide input and endorsement on the strategic directions to be pursued.

Strategic Health System Plan Steering Committee

The Strategic Health System Plan Steering Committee provided oversight in the development of the Plan and advised HNHB's Leadership team throughout the planning process. The LHIN selected the Steering Committee members to reflect a broad spectrum of partner interests, perspectives and expertise from across HNHB LHIN. The Steering Committee met to provide this broad and diverse perspective at key project milestones, providing the LHIN Chief Executive Officer (CEO) and staff with additional insights to inform Plan development.

Provider Working Group

The Provider Working Group (PWG) provided input into specific project deliverables. The PWG was charged with engaging other providers at various points to broaden and deepen the local stakeholder input into the Plan's development. PWG members were selected by the HNHB LHIN to reflect the perspectives and expertise of existing groups, committees, and networks from across the HNHB.

The development of the five-year SHSP followed a robust process, including:

- A comprehensive environmental scan, including a review of population, demographics, health status and utilization data.
- A literature review of lessons learned from other high performing systems around the world.
- Significant engagement input and feedback from stakeholders, including, citizen provider organizations, physicians and other stakeholders such as elected officials.

The HNHB LHIN pioneered new ground as part of its strategic planning process by engaging citizens across our communities through Citizens' Reference Panels. Through the CRPs, the HNHB LHIN engaged community members, along with legislatively defined priority populations - Aboriginal peoples and Francophones, to solicit thoughts and feedback on the needs and preferences of the health system users.

Based on what we heard from citizens, and from our analysis of other inputs, the following principals were identified to guide future transformation of the health system:

- Improve the patient experience.
- Ensure alignment with the common vision and philosophy of care.
- Improve quality.
- Promote integration.

- Enable enhanced sustainability.

The overall aim of the HNHB LHIN, over the course of the next five years, will be **to dramatically improve the patient experience through quality, integration and value.**

Our three key strategic directions, flowing from this aim will be to:

1. *Dramatically improve the patient experience by embedding a culture of quality throughout the system.*
2. *Dramatically improve the patient experience by integrating service delivery.*
3. *Dramatically improve the patient experience by evolving the role of the LHIN to become Health System Commissioners.*

These strategic directions will form the basis of the LHIN's work over the coming five years.

Integration - Health Links as a new model of integrated care delivery

Dramatically improving the patient experience by integrating service delivery begins at the local level, integrating care delivery for a group of individuals, one person at a time.

Ontario is improving care for seniors and others with complex conditions through **Health Links.** This innovative approach brings together health service providers in a community to better and more quickly coordinate care for high needs patients.

Health Links are the cornerstone of the SHSP direction to dramatically improve the patient experience by integrating service delivery.

Patients with the greatest health care needs make up five percent of Ontario's population but use services that account for approximately two-thirds of Ontario's health care dollars. Better coordination of care for these patients will result in better care and significant health system savings that can be devoted to other patients, ultimately improving the sustainability of public health care.

Each Health Link will measure results based on a common set of 11 indicators, including:

1. Ensure the development of coordinated care plans for all complex patients
2. Increase the number of complex patients and seniors with regular and timely access to a primary care provider
3. Reduce the time from primary care referral to specialist consultation
4. Reduce the number of 30 day readmissions to hospital
5. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
6. Reduce time from referral to home care visit
7. Reduce unnecessary admissions to hospitals
8. Ensure primary care follow-up within 7 days of discharge from an acute care setting
9. Enhance the health system experience for patients with the greatest health care needs
10. Achieve an ALC rate of 9 per cent or less
11. Reduce the average cost of delivering health services to patients without compromising the quality of care

Health Links is a new model of care where all providers in a community, including family care providers, specialists, hospitals, long-term care, home care and other community supports, are charged with coordinating plans at the patient level.
This coordinated approach will help improve patient transitions within the system and help ensure patients receive more responsive care that addresses their specific needs with the support of a tightly knit team of providers.

The move to Health Links was announced by the Minister of Health and Long-Term Care in December 2012, and the HNHB LHIN has moved quickly to implement this innovative. Significant progress has been made in engaging stakeholders, mapping out Health Link geographies, and establishing the first of several Health Links and continued implementation will be a priority in 2013-14.

Clinical Program Integration

Continued clinical services planning directly aligns with the LHIN's Strategic Health System Plan for a local integrated health care system where individuals experience care that is coordinated, of the highest quality, cost effective and results in better outcomes for the population.

The HNHB LHIN follows a consistent process to develop LHIN-wide integrated clinical programs. This process has achieved great success with measurable outcomes as evident through the Integrated Cancer Services Plan, Integrated Vascular Clinical Services Plan and Thoracic Clinical Services Plan. Success is attributed to a defined process with clear expectations, strong physician engagement and leadership, and strong administrative and organizational leadership.

LHIN-wide Integrated Clinical Programs

The key concept behind LHIN-wide integrated clinical programs is "one program on multiple sites". All residents across the HNHB LHIN should have access to a coordinated program with the same approach to care delivery and the same quality standards. This required increased standardization and the reduction of clinical variation across providers, using:

- Common definitions and patient flow processes
- Common care models and quality improvement process, based on leading practices
- Common outcomes, goals, deliverables and metrics

Examples of how specific HNHB LHIN clinical services plans have demonstrated accomplishments include:

- The Integrated Cancer Services Plan has established a single program of service delivery administered for patients at several sites across the LHIN
- The Integrated Vascular Clinical Services Plan has established a no refusal policy for vascular surgical patients with stringent monitoring to ensure patients have access to and receive appropriate care in the most appropriate location.
- The Thoracic Clinical Services Plan has demonstrated a decreased length of stay for non-malignant thoracic surgical patients due to increased capacity through outpatient services at hospitals across the LHIN. This has been accomplished through collaboration with the Community Care Access Centre (CCAC) for in-home services and support.

Interprofessional Care

The HNHB LHIN has focused the advancement of interprofessional care through the Health Professional Advisory Committee (HPAC). The implementation of Health Links across our LHIN will also enhance interprofessional care across all sectors of health care. *For an update on interprofessional care, please see the HPAC section on page 18.*

Community-Based Health Service Capacity

In 2012-13, the Ontario government increased support for home care and community services across the province. The HNHB LHIN received an increase of $14.7 million from the province and invested an additional $400,000 for a total investment in community-based services of $15.1 million. This investment supported seniors and other individuals to receive services closer to home, reduce emergency department wait times, improve alternate level of care rates and reduce avoidable hospital readmissions.

The LHIN invited health service providers to submit proposals based on four targeted areas:

- Assisted Living and Supportive Housing Services for High Risk Seniors
- Building Hospice Palliative Care community capacity across the continuum of care High Risk Seniors and Other Ontarians
- Mental Health and Addictions (MH and A) Services (withdrawal management and aftercare; intensive case management services; supportive housing; and crisis capacity)

In reviewing the 98 proposals received LHIN staff considered population health care needs and the availability of community services across the LHIN, as well as the priorities of the LHIN and government to recommend the optimal allocation of resources given the dollars available. The board-approved review process and decision-making framework allowed staff to bring forward 22 proposals for board approval.

Ultimately, the LHIN invested in new and expanded programs and services across communities to support individuals with mental health and addictions issues, support high risk seniors, increase assisted living services, falls prevention and palliative care supports.

This $15.1 million investment supported the LHIN's Strategic Health System Plan and will help to continue to support the Minister's Action Plan for Health Care.

Better Access to Assisted Living Services

The expansion of assisted living services for high risk seniors was identified as a key priority for new community sector funding. It is aligned very specifically with the Ministry of Health and Long-Term Care's direction to the LHIN to focus new investments on services to support seniors to remain in the community. Funds were also allocated to Personal Support Worker (PSW) hours delivered by health service providers of Assisted Living Services for High Risk Seniors.

HNHB LHIN investments in assisted living services for high risk seniors are aligned with the ministry's policy, as outlined in the 'Updated Assisted Living Policy for High Risk Seniors', January 2011. The policy's purpose is to create a more comprehensive continuum of care for seniors, who live in their own homes and do not require admission to a long-term care (LTC) home, but whose needs cannot be met in a cost-effective manner through home and community care services provided solely on a scheduled visitation basis.

- The LHIN's call for proposals for Assisted Living Services for High Risk Seniors required service providers to demonstrate the potential to:
    - Reduce the wait time in community and hospital for personal support services.
    - Transition CCAC clients to community support service agencies.
    - Reduce avoidable 911 calls, ED visits and hospital readmissions by high risk seniors.
    - Increase the number of high risk seniors discharged home without an ALC designation.
- Seniors aged 75+ who live alone in their own homes in the community and meet the Ministry's eligibility criteria for assisted living services for high risk seniors were considered the 'high risk seniors' target population for the new funding.
- The LHIN quantified the 'high risk seniors' target population by sub-LHIN geographic area as per the criteria noted above.

The LHIN then funded those community support service agencies whose geographic catchment areas included a relatively large population of 'high risk seniors' and who demonstrated an ability to leverage existing resources – through partnerships and existing infrastructure, in order to maximize the amount of new funding directed to front line/hands on care for seniors. In total, eight Assisted Living proposals received funding, as follows:

- Ontario March of Dimes – Wellness Centre and Outreach Hub
- Ontario March of Dimes – Niagara Falls Hub
- Region of Niagara – Overnight Personal Support at Deer Park Suites
- Brain Injury Community Re-entry Niagara – Supporting Independent Living
- Niagara Ina Grafton Gage Village – Expansion of Supportive Housing Services
- Participation House Brantford – Supportive Housing Hub
- United Mennonite Home – Personal Support Services
- Good Shepherd Centre Hamilton – Emmanuel House

Mental Health and Addictions

One in five persons or 280,000 people, in the HNHB LHIN will be affected by mental illness at some point in their lives *(Source: Health Canada, A Report on Mental Illness in Canada, 2002)*. Approximately 42,000 people, or 3% of people in the LHIN, depend on alcohol or illicit drugs in a given year *(Source: Prevalence of Co-occurring Substance Use and other Mental Disorders in the Canadian Population, Canadian Journal of Psychiatry, December 2008)*. Key issues facing people with mental health and addictions include social stigma, access to services and basic supports including housing, income and social inclusion.

Identifying Areas for Health System Improvement

Focus groups were hosted across the LHIN with key stakeholders from various care settings to discuss reducing unplanned visits to the emergency department by persons with a mental health and/or addiction. These conversations resulted in a more in-depth understanding of the issues and recognition of the importance of both hospital and community-based providers being involved in finding sustainable long-term solutions.

In the HNHB LHIN:

- 10-20% of residents will have a substance use disorder in their lifetime.
- 70% of people with mental health issues have been diagnosed before age 18.
- 98,000 children and youth do not get the mental health treatment they need.

Over a one year period, 30 individuals with a mental health issue and/or addiction accounted for nearly 2,200 visits to hospital emergency departments. An analysis was conducted to understand why this occurred and to help identify areas for health system improvement. Representatives of LHIN hospitals and community-based mental health and addictions providers have agreed to pilot a consistent approach to address this issue. Through this collaborative approach, system-wide improvements, issues and gaps in service were identified and priorities set.

Better Access to Mental Health and Addictions Services

As a result of this work a wide variety of programs and services have been funded to meet the mental health and addictions needs of residents in the LHIN, including:

- Expansion of the continuum of crisis capacity and intensive case management in Brant and Haldimand Norfolk.
- Expansion of the Community Treatment Orders at St. Joseph's Healthcare Hamilton (SJHH).
- Introduction of a mobile concurrent disorders program in Brant and Haldimand Norfolk with a focus on serving persons with opioids addictions.
- Expansion of program serving pregnant and parenting women with addictions in Niagara and Hamilton.
- Creation of a new urgent access multidisciplinary team in Niagara with a focus on serving persons with opioids addictions.

St. Joseph's Healthcare Hamilton (SJHH) is the regional centre for mental health and addictions in the HNHB LHIN. In 2013 there will be an expansion of specialized mental health beds and services at the Niagara Health System (NHS) and SJHH.

Linking People with the Right Services

The LHIN introduced the Ontario Common Assessment of Need (OCAN) tool with all mental health service providers. This tool identifies individuals' needs and helps match them to existing services.

Consultation with provider organizations and consumers has resulted in a tailored approach that meets the specific needs of the LHIN. The individual assessments will form part of a larger database, linking assessments across sectors.

Implementation of this Integrated Assessment Record (IAR) will:

- Support a client centred approach to care.
- Ensure the secure transfer of personal health information.
- Facilitate faster care planning and collaboration.
- Result in workload reduction.
- Increase in the reliability and quality of client information.

Building Capacity to Support Individuals with a Mental Health and/or Addictions issue Through Training

As part of the community investment process this year, funding was provided to deliver SafeTALK and Applied Suicide Intervention Skills Training (ASIST), a best practice, evidence-based course on suicide prevention. This education initiative helped to ensure health service providers, school staff, aboriginal providers, families and caregivers working with persons that they serve who may be at risk of suicide felt competent in having a conversation on this daunting topic.

Mental Health First Aid (MHFA) is intended to provide staff who do not normally work with individuals experiencing mental health issues with the skills and knowledge to help a person developing a mental health problem or experiencing a mental health crisis until appropriate treatment is found or until the crisis is resolved (similar to physical first aid). Funding was provided for 24 staff from community-based health service provider agencies to participate in the Mental Health First Aid Instructor Training sessions. This is a best practice, evidence-based course developed by the Mental Health Commission of Canada.

"Living Life to the Fullest" training empowers individuals to understand why they feel as they do, and to learn new ways of improving how they feel and teach key life skills. It has proven effective in helping people develop life skills that help them tackle feelings of low mood, stress and distress in a non-stigmatized way. Ten staff of the Canadian Mental Health Association (CMHA) in the HNHB LHIN participated in this Facilitator Training Program.

Moving Ahead on the Provincial Government's Mental Health and Addictions Three-Year Plan
Implementation of the government's Mental Health and Addictions three-year strategy focusing on children and youth is well underway. The Ministry of Health and Long-Term Care and the HNHB LHIN are participating through the following initiatives:

- Introduction of Nurses in District School Boards.
- Eating Disorders – inpatient beds at Hamilton Health Sciences and Nurse Practitioner positions.
- Participation in a service collaborative to identify and move forward on implementation of process improvements related to transitions.
- Transitional Aged Youth - supporting children with mental health and those persons with a developmental disability to transition from the children's to the adult mental health sector.

Moving Forward on a LHIN-wide Falls Prevention Strategy

There were more than 13,000 visits by seniors to a hospital emergency department and more than 3,800 seniors hospitalized as a result of a fall in 2010-11. Seniors who have multiple chronic diseases are often at risk of falls due to complications and health issues related to these conditions and in the HNHB LHIN more than 50% of seniors have two or more chronic conditions (4% higher than the provincial average). Research shows a multi-factor approach to falls is effective in reducing the number and frequency of falling. The risk factors for falls and chronic disease are indeed the same. They include the inappropriate use of medications, poor nutrition, lack of physical activity/poor mobility, unsafe/hazardous home environment and unsafe/inaccessible external environment. . .

Over the past year, extensive planning and research was conducted on better understanding the medication risk factor and best practice strategies to address this risk. It is widely known that seniors have multiple chronic diseases, managed with multiple medications, and that their ability to manage complex drug regimens is compromised by their diminishing cognitive and physical capacity to administer their own medicines. Consequently, elderly persons are four times more likely than adults of other ages to be hospitalized because of adverse drug reactions.[5]

Through consultation with key stakeholders a foundation was built for an HNHB LHIN-wide Falls Prevention framework which has served as a consistent reference point and a common vision about what is needed for an effective falls prevention and management strategy. The Strategy provides a common understanding of

[5] Beijer H.J.M and C.J. de Blaey, (2002) "Hospitalizations caused by adverse drug reactions (ADR): A meta-analysis of observational studies" Pharm World Sci 2—2:46-54)

the falls risk factors identified in the research and has helped to guide efforts for cross-sector collaboration within the broader community in the HNHB LHIN. The Strategy includes positive messaging and program development based on best practice (collaboratively developed by the Public Health Departments in the LHIN), a coordinated implementation approach by health service providers funded for falls programs, and a performance measures framework which allowed a comparison of outcomes across programs.

The overall goal of the HNHB LHIN's Falls Prevention Strategy is to reduce the number and severity of falls amongst seniors in the HNHB LHIN through raising awareness and implementation of programs to address risk factors and to reduce avoidable Emergency Department (ED) visits, hospitalizations and readmissions as a result of a fall.

In 2012-2013 the following interventions were funded through the Aging at Home Strategy and implemented to reduce falls:

- Best practice falls prevention exercise programs.
- Mobile continence care clinics.
- Mobility assessments (fitting for assistive devices).
- Home safety assessments (identifies safety risks and helps to implement changes).
- Foot care clinics for high risk seniors (i.e. diabetes and chronic kidney disease)

As a result of a comprehensive evaluation of all falls programs in the HNHB LHIN, decisions were made to permanently fund programs given successes illustrated through the outcome measures. While some adjustments were made to improve access to the target population, further coordination and refinement of the various falls prevention and exercise programs also occurred given evidence about the positive impact the programs have had reducing falls.

Chronic Disease Prevention and Management

According to the Canadian Community Health Survey, 16.7% of the HNHB LHIN population has more than one diagnosed chronic condition such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes. This number is steadily rising due to the LHIN's aging population.

Among residents with diabetes, complications are experienced by many; each year more than 200 people in the LHIN have a foot or lower limb amputated due to complications with diabetes. A number of activities over the past year have contributed to better care for people with chronic conditions. Several examples include the expansion of foot care for diabetic patients and the implementation of a Rapid Response Transition Care Team (See patient flow section).

In 2012 the Ministry of Health and Long-Term Care announced the accountability for the diabetes regional coordinating centres (DRCCs) and diabetes education programs (DEPs) would move from the hospital sector and community health centres to the LHINs in order to facilitate better coordination and improved access for residents. Where possible, current DRCC staff transferred to the LHIN organization and where necessary additional staff were hired in order to support the new accountabilities. The HNHB LHIN office was able to support the additional staff within its current facility – no additional space has been required.

eHealth

The HNHB LHIN eHealth office plays a lead role in harnessing information technology and innovation to improve patient care, safety and access for the residents of the LHIN in support of the government's health strategy. Provincially, eHealth Ontario has evolved Ontario's Electronic Health Record (iEHR) Strategy, moving from a centralist model to one of regional hubs.

LHINs are grouped into three hubs or eHealth clusters:

- Southwest Ontario (SWO): Erie St. Clair, South West, Waterloo Wellington, and Hamilton Niagara Haldimand Brant.
- Greater Toronto Area (GTA): Central West, Mississauga Halton, Toronto Central, Central, Central East, and North Simcoe Muskoka.
- North East Ontario (NEO): South East, Champlain, North East, and North West.

Province-wide information sharing and access to provincial information assets are achieved by linking the regional hubs to a provincial hub. eHealth Ontario is establishing the information technology (IT) standards to be used in implementing each regional hub. SWO and NEO are building on the work of GTA to integrate and share data and have launched accelerated planning projects. SWO is positioned to rapidly deliver a first generation iEHR for approximately four million Ontarians that will span a significant portion of the continuum of care.

Integrated Decision Support (IDS) Warehouse

The IDS Business Intelligence Solution is a powerful decision support system that supports system-wide planning and performance reporting. IDS is a centralized data warehouse containing current, detailed information for patients in hospital beds (acute, rehabilitation, mental health and complex continuing care), ER visits, same day surgery, medical day care clinics, CCAC client and assessment data, Community Health Centre (CHC) client and provider data, and ALC Information System (ALC-IS) patients.

It is linked by an identification that is specific to an individual that connects data from all data sources allowing the approved users of the IDS to follow a patient's journey through the health care system. In addition to a patient's clinical information, hospital-specific financial and statistical information are available for three year trending. In the LHIN, over 10 hospital corporations representing 23 sites contribute data, in addition to CHCs and CCAC data, as well as Cambridge Hospital in the Waterloo Wellington LHIN.

Over the next 18 months, additional hospitals from four other LHINs (Waterloo Wellington, Toronto Central, Southwest, and Champlain) are committed to, or are in discussion about joining and leveraging IDS. Go-live is planned to start as a staggered process in early summer for both Toronto Central LHIN and South West LHIN. Re-engagement of Waterloo Wellington LHIN to join IDS, as well as two other LHINs in the province, are asking for meetings related to costs and implementation for them to join.

New datasets related to ambulatory cancer centre patient data were incorporated and those patient's journeys linked within IDS in the fall of 2012 (HNHB LHIN Regional MOSAIQ implementation). In addition, the exploration of adding EMS (Ambulance and Paramedic) information to enhance the ER patient journey reporting is under way, as well as improved system and infrastructure functionality to IDS is being undertaken. Improved data model for ALC-IS and CCRS (complex care) was implemented in IDS. Behavioural Supports Ontario (BSO) flags were implemented in IDS to follow behavioural patients across the LHIN. Additional Reports and enhanced "patient profile" screens were also added to IDS.

There are over 250 registered users (primarily analysts). Integrating data from IDS into ClinicalConnect as part of a "portal to portal" approach is being considered since it can provide valuable complementary information to clinicians at the point of care and to assist ER providers.

ClinicalConnect

ClinicalConnect is a secure, provider portal or dashboard that gives authorized physicians and health care providers involved in a patient's circle of care, real-time, anytime and anywhere access to electronically stored patient records. ClinicalConnect is an integration framework key to accessing and sharing health information regionally across the continuum of care including provincial data sources as they become available.

Today, ClinicalConnect provides a virtual Electronic Health Record (HER) for the HNHB and Waterloo Wellington LHINs, representing more than two million patients. It links data from 28 hospitals across the two LHINs. It also includes oncology notes from the Juravinski Cancer Centre in Hamilton, and the Walker Cancer Centre in St. Catharines, as well as information from the HNHB and WW CCACs. There are over 5000 users accessing millions of labs and reports per month. The Grand River Hospital, the last remaining major hospital, will be live March 27, 2013. OLIS (Ontario Lab Information system) private lab data will be integrated with existing lab data from regional hospitals by June 2013. Also in June 2013, HOBIC Nursing Assessment data will be available. An e-referral pilot project has been initiated, leveraging CCAC's CHRIS system and ClinicalConnect. Additionally, ClinicalConnect can be an enabler to the Health Links initiatives.

Regional Diagnostic Imaging Project

The Regional Diagnostic Imaging project has continued to complete integration with regional hospitals and is also working to integrate and deploy the Diagnostic Imaging repository (DI-r) via ClinicalConnect. Live sites include eight hospitals in the LHIN and three hospitals in WW LHIN. ClinicalConnect integration to the DI-r is in progress with expected implementation later in 2013.

CCIM Repository for Mental Health and Addictions

The Community Care Information Management (CCIM) Repository for Mental Health and Addictions system is nearing completion. The database resides in a repository in the Erie St. Clair LHIN. The intent is to integrate this repository into ClinicalConnect in the future.

eHealth Ontario Projects

The LHIN was successful in receiving provincial eHealth Ontario funding to assist with a number of projects. This will help the LHIN advance its local strategic plan, aligned with government priorities. The LHIN is central to many projects, and continues to work with other LHIN partners in Southwestern Ontario, eHealth Ontario and Canada Health Infoway. Examples of projects supported through funding from eHealth Ontario, Canada Health Infoway and the LHIN include:

- ClinicalConnect expansion and enhancement of the support and infrastructure.
- Increased user adoption and change management.
- Expansion of ClinicalConnect to LHINs 1 and 2.
- Integration of private laboratory data from the Provincial OLIS database adding to the existing hospital-based lab data within ClinicalConnect.
- Integration of the DI-r into ClinicalConnect to provide access to x-rays, MRI's and other images the patient may have had elsewhere in the region.
- Integration with provincial databases that enable improvements in patient transitional care.
- Mobile access to ClinicalConnect is being deployed, assisted by Canada Health Infoway funding.

- Implementation of the Regional Oncology program ambulatory care software made possible with funding support from Canada Health Infoway.

Much of the success in obtaining funding for this work arises from the LHIN's interest in working with other LHIN partners. By building partnerships and coordinating resources, the four LHINs in the SWO regional hub are working toward building an efficient and effective e-health system for the residents of our communities.

Patient Flow

Patient Flow continued to be a key area of focus for the LHIN in 2012-13. This year LHIN providers under the leadership of the HNHB LHIN Alternate Level of Care (ALC) Steering Committee continued to implement the LHIN's three-year Patient Flow Action Plan, which was developed in 2011 with the goal of achieving sustainable improvement.

Patient Flow focuses on the movement of individuals across the health care system (continuum) from the community to acute in-patient hospital care, from acute to post-acute care or home. While it is not unexpected that situations will occur where individuals will experience a wait across the continuum, issues arise when individuals experience long waits in a hospital setting or when large number of individuals wait in hospital for a post-acute setting. Both situations can impede patient flow and negatively impact the individual and health system.

Individual perspective:

- Individuals' recovery may be delayed or in the case of seniors may regress both physically and mentally while waiting for the appropriate post acute care setting.
- Unnecessary long hospital stays expose individuals to a higher risk of hospital acquired complications.

System perspective:

- Hospitals can become challenged when individuals need to be admitted for an acute illness or planned surgery if a high number of individuals that no longer require acute hospital care are waiting in hospital for an alternate level of care. This may result in the cancellation of elective services, long emergency department (ED) wait times, or delays in receiving required services.

One of the metrics used by the LHIN to measure the number of days an individual waits in hospital for an alternate level of care (ALC) is the acute ALC rate. A low rate means that individuals spend less time waiting in an acute hospital for post acute care. The post acute care setting individuals wait for depends on their immediate and long-term care needs and include: post acute restorative/convalescent care, complex care, rehabilitation services, home with community support services, mental health services, assisted living/supportive housing and long-term care home.

The LHIN monitors the number of days an individual waits in hospital for an ALC setting two ways:

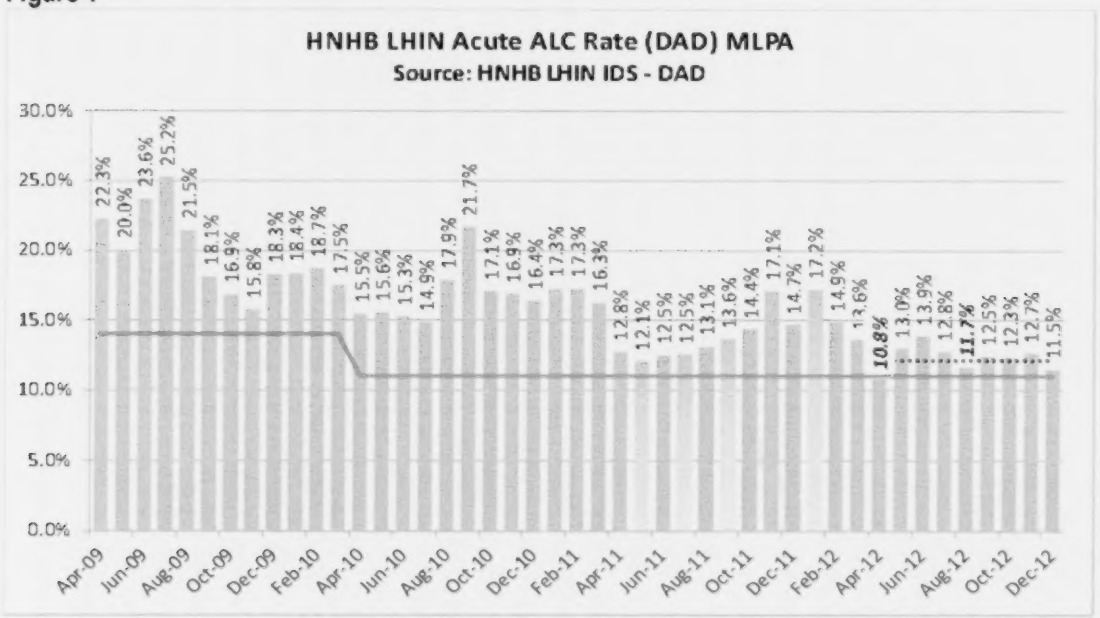
- The total number of days that individuals have waited in hospital for an ALC setting by the time they were discharged. These are referred to as closed cases.
- The number of days that individuals still in hospital are waiting for an ALC setting. These are referred to as open cases.

Successes over the past year:

- Achieved a sustained improvement in the LHIN's Acute ALC rate, since May 2012 the ALC rate has reported an ALC rate of less that 14%, with the lowest rate of 12.1% reported in December 2012[6] (Refer to Figure 1).
- Reduced the number of patients waiting in hospital for an alternate care setting from 656 in January 2010 to 391 November 2012 (Refer to Figure 2).
- Reduced the number of patients waiting in hospital for long term care (LTC) from 360 in August 2010 to 133 in January 2013[6], the lowest number reported since 2009.
- In November 2012, the LHIN reported the lowest number of ALC days in a month (7,676) since reporting started in 2009 – this is a 100% improvement over the 15,428 ALC days reported in June 2009.[6]
- As of December 2012, 906 patients were admitted to the LHIN's Assess Restore programs and over 77% of these patients were discharged home.[7]
- Implemented a Rapid Response Transitional Care Team (R2T2) to support patients with complex medical conditions return home from hospital and be supported at home. As of September 2012, the program had supported 190 patients return home from hospital and 150 clients in the community.[8]
- Continued to support patients needing higher levels of community support return home from hospital, between April 1 – September 30, 2012:
    - 1,660 individuals supported at home on service maximums.[9]
    - 529 patients have been discharged from hospital on Home First, 478 of these patients were seniors.
    - 37% of patients taken home from hospital were identified as needing high levels of care.[10]
    - An estimated 22,242 ALC days prevented as a result of supporting patients with higher care needs in their homes.[11]

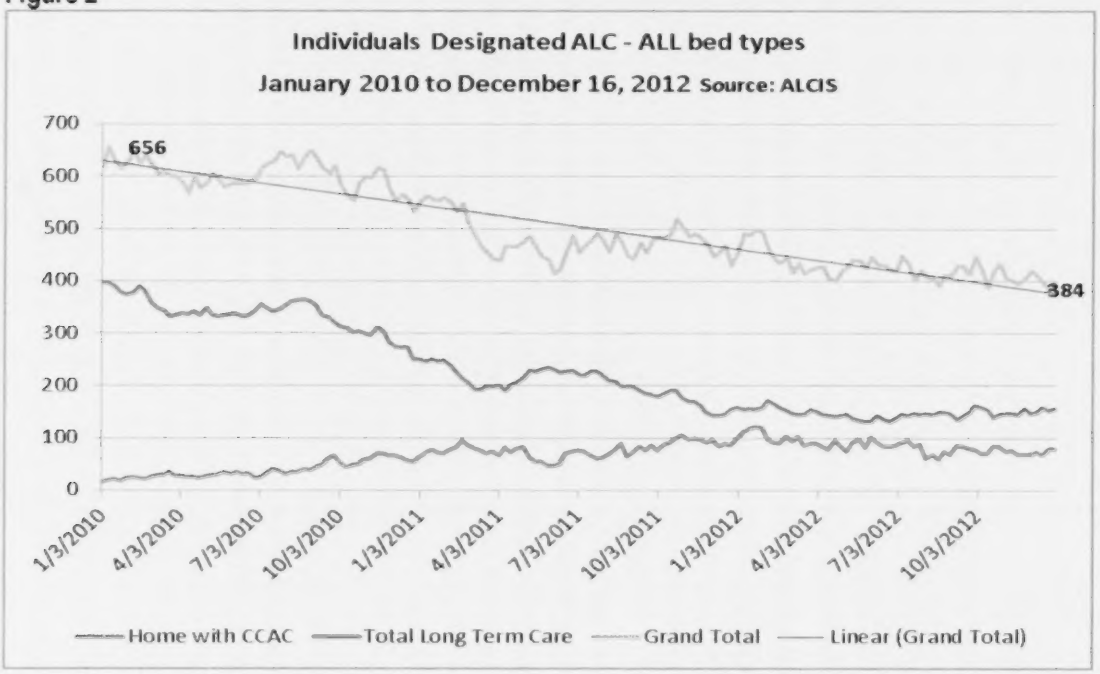
[6] HNHB LHIN Weekly Hospital ALC Trigger Report January 2013.
[7] HNHB CCAC ALC Report December 2012.
[8] HNHB CCAC R2T2 September 2012 Report.
[9] HNHB CCAC 2012-13 Second Quarter Report.
[10] HNHB CCAC Q2 2012-13 Home First Data October 2012.
11 HNHB LHIN Community ALC Investment Report November 2012.

Figure 1



Note: The increased number seen in November 2011 and January 2012 is the result of successfully discharging a number of individuals that experienced long waits in hospital for the right care setting.

Figure 2



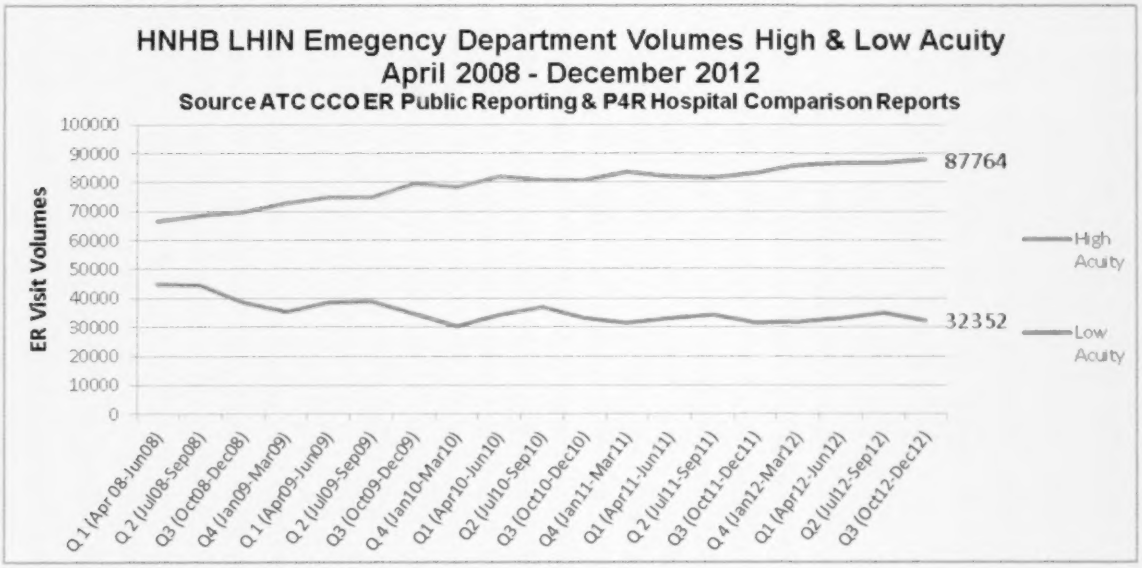
Emergency Department (ED) Length of Stay

The ED length of stay (LOS) reflects the entire time individuals spend in the ED, from the time they register or are triaged (whichever occurs first) to the time when they leave the ED or are admitted to an inpatient hospital bed. During this time the person sees the medical staff and receives care.

The ED LOS is measured at the 90th percentile, which is the time the ninth cut of ten people waited. For example, if 10 individuals visited an ED and eight were treated and each left the ED within two hours of the time they were registered but it took the ninth person eight hours to complete their visit, then the 90th percentile wait time is eight hours.

The LHIN has 13 EDs across nine hospital corporations. This year LHIN hospitals reported an escalation in the number of ED visits in an already increasing trend that was seen in 2011-12. As of December 2012, LHIN hospitals reported 361,969 visits[12], 16,807 additional visits over the same period in 2011-12.[13] The increased ED visits are seen in the high acuity population (Refer to Figure 3) and in the admitted patient population). The number of patients with low acuity needs was relatively stable over the year.

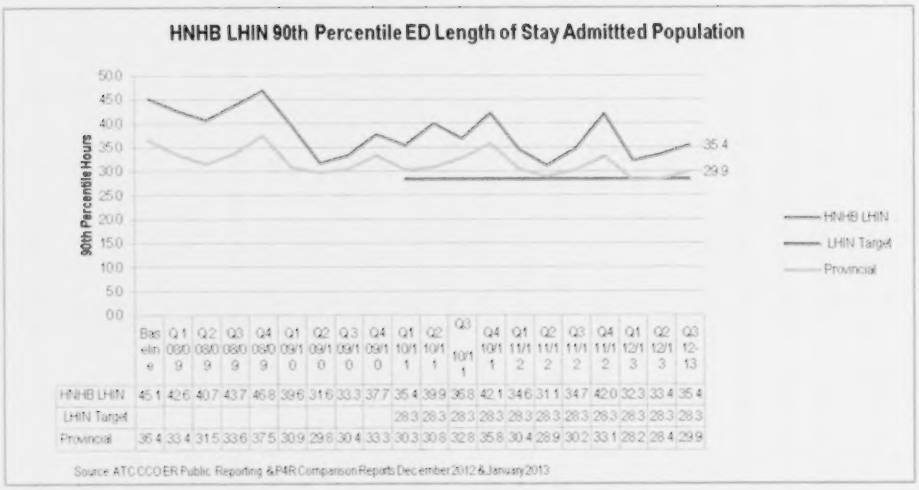
Figure 3



- While LHIN hospitals continue to implement a number of initiatives to reduce the time people spend in the ED, they continue to be challenged in sustaining improvements. A review of the LHINs performance for this measure shows that the LOS increases during the fall and winter months. While the LHIN's performance mirrors that of the province it has been unable to reduce ED LOSs to equal or lower than that reported for the province (Refer to Figure 4).

[12] ATC CCO ER Public Reporting & P4R Hospital Comparison Report December 2012.
[13] ATC CCO ER ER Historical Public Reporting and P4R Hospital Comparison Report Apr08 to Mar12 & January 2013.

Figure 4

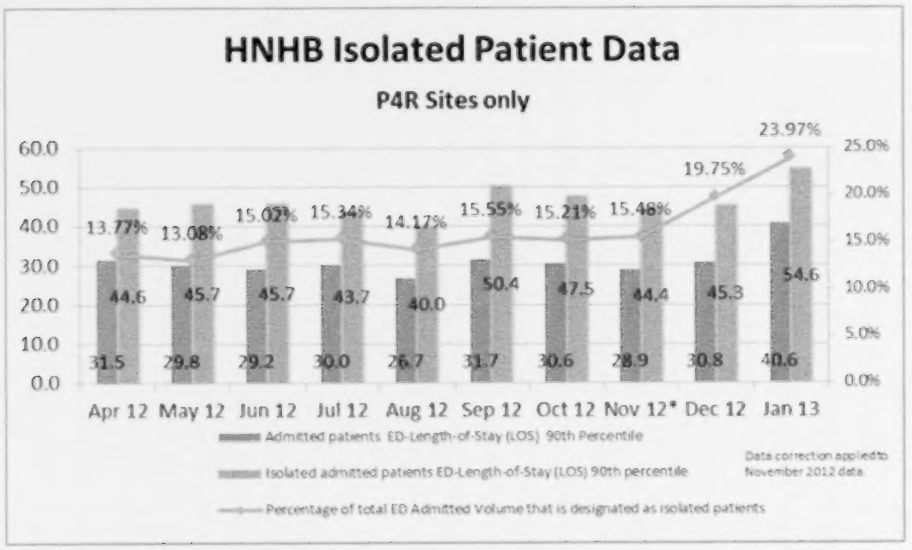


	Baseline	Q1 08/09	Q2 08/09	Q3 08/09	Q4 08/09	Q1 09/10	Q2 09/10	Q3 09/10	Q4 09/10	Q1 10/11	Q2 10/11	Q3 10/11	Q4 10/11	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12-13
HNHB LHIN	45.1	42.6	40.7	43.7	46.8	39.6	31.6	33.3	37.7	35.4	39.9	35.8	42.1	34.6	31.1	34.7	42.0	32.3	33.4	35.4
LHIN Target										28.3	28.3	28.3	28.3	28.3	28.3	28.3	28.3	28.3	28.3	28.3
Provincial	35.4	33.4	31.5	33.6	37.5	30.9	29.6	30.4	33.3	30.3	30.8	32.8	35.8	30.4	28.9	30.2	33.1	28.2	28.4	29.9

Factors identified by LHIN hospitals impacting the admitted patient LOS include:

- Increase in the number of ED visits.
- Increase in the number of seniors with more complex conditions presenting to the ED.
- A higher number of individuals requiring isolation precautions. Individuals requiring isolation precautions experience a longer LOS as they need to wait for an appropriate bed (Refer to Figure 5).
- Availability of inpatient beds.
- LHIN long-term care homes with admission restrictions due to outbreaks (i.e. flu/influenza).

Figure 5



Key Activities to Reduce ED Demand and ED LOS

Pay for Results (P4R)

Eight LHIN ED sites across five hospital corporations participated in the Pay for Results program. Through this strategy, hospitals receive one-time funding to implement process improvements focused on reducing the time people spend in the emergency department by implementing initiatives to streamline patient flow. These initiatives included Rapid Assessment Zones for low acuity patients, Patient Flow Coordinators, enhancing ED support services, additional Triage Nursing time, and additional ED Physician hours. .

Participating HNHB LHIN Hospitals:

- Brant Community Healthcare System
- Hamilton Health Sciences
  - Hamilton General Hospital
  - Juravinski Hospital and Cancer Centre
  - McMaster Children's Hospital
- Joseph Brant Hospital
- Niagara Health System
  - St. Catharines Site
  - Niagara Falls Site
- St. Joseph's Healthcare Hamilton

Community Care Access Centre (CCAC) Case Managers

Larger EDs within the LHIN have CCAC Care Coordinators working within them. As of January 2013, 3,118[14] emergency department admissions were potentially avoided as a result of CCAC care coordinators being located in emergency departments. Where appropriate, CCAC care coordinators can arrange for care to be provided in the community rather than in hospital.

Screening Tool for High Risk Seniors

This year LHIN hospital and the CCAC worked together to implement an evidence based screening tool, to identify seniors who may be a high risk and need community supports. The tool piloted in 2011-12 at two LHIN hospitals will be used in all LHIN EDs by March 31, 2013. As of December 31 2012:

- 648 individuals were screened and identified as high risk, of these 373 were not known to CCAC and have been connected to community services. The services provided to these people varied and had a total cost of $685,720[15].

Health Care Connect

This program, operated by the HNHB Community Care Access Centre, connects residents without a family doctor to primary care. Connecting as many residents as possible with a primary care physician will reduce the demand on the EDs. As of December 2012, of the 10,027 eligible patients registered with the program, 95.38% had been referred to a primary care provider and 89.44 % of clients were referred within less than 30 days[16].

Increased Access to Urgent Care Centres (UCC)

There are six Urgent Care Centres in the LHIN. Residents with less acute emergent health care needs can be treated at urgent care centres quicker than emergency departments. From April 2012, to February 2013, LHIN UCCs reported 135,427 visits and were able to see clients within recommended time frame almost 100% of the time.[17]

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[14] HNHB CCAC Monthly Report January 2013.
[15] HNHB CCAC Monthly Data Report December 2012.
[16] HNHB Health Care Connect Data December 2012.
[17] IDS, ED Wait Times Report April 3, 2013.

General Internal Medicine Rapid Assessment Clinics (GIMRAC)

The two GIMRAC Clinics located at Hamilton Health Sciences' McMaster Site and St Joseph's Healthcare Hamilton's Charlton Campus continued to see increased demand in 2012-13. These clinics, funded through the LHIN's Aging at Home strategy, facilitate access to General Internal Medicine (GIM) consultations through an out-patient clinic. The program reduces ED wait times by providing access to General Internal Medicine physicians within a 24-48 hour period of time, thereby allowing ED physicians to safely discharge patients that can be seen on an out-patient basis rather than waiting in the ED.

As of September 2012, the two clinics reported seeing 1,920 new clients and 895 clients for follow up visits of the clients seen, 312 considered ED diversions and 212 were discharged early from the hospital because of follow-up clinic. One of the programs reported a 70% reduction in the ED length of stay for patients seen in the clinic that required a GIM consult compared to those who were seen in the ED for a GIM consult.[18]

Emergency Services Steering Committee

The LHIN's Emergency Services Steering Committee (ESSC) provides leadership to LHIN health service providers and the LHIN organization in the planning and implementation of initiatives to improve service quality and wait times for emergency services within the LHIN community.

In 2012-13, a number of projects funded the previous year reported on their results:

- Community Referrals by Emergency Medical Service (CREMS) initiative was spread to Burlington, Haldimand, Brant and Niagara in 2012-13. The program is planned to be implanted in Norfolk County in 2013-14. As of August 2012, the CREMs program in Hamilton made 660 referrals to the HNHB CCAC, of these, 92% resulted in new services being initiated.[19]
- The McMaster Emergency Medicine Research Group (MEMRG) completion of a study funded by the LHIN Emergency Services Steering Committee (ESSC) examining ED Quality Indicators for the treatment of: Migraine, Asthma, Sepsis, Stroke, and Acute Myocardial Infarction (AMI). The ESSC is working with the LHIN ED Chief and the Chiefs for the various EDs to implement recommendations; the first set of recommendations to be implemented relate to the management of Migraines in the ED.
- Hamilton Health Sciences partnered with St. Joseph's Healthcare Hamilton and community Mental Health and Addictions providers to reduce the utilization of the ED by the segment of the population who are high users of this service. This work is ongoing, but the preliminary results are positive.

Behavioural Supports Ontario (BSO) Project

The BSO strategy focuses on improving care and system navigation for individuals/caregivers who have, or are at risk of responsive behaviours. All LHIN activities related to BSO is driven by the following value statement which represents the voice of the individual with responsive behaviours.

"I am who I am so help me continue to be me."

[18] Quarterly Performance Reports Q2 2012-13 HHSC & SJHH
[19] Hamilton Emergency Medical Services

In 2012-13 the LHIN further developed and implemented four of the improvement plans identified in its BSO Action Plan. These included:

- BSO Connect – a single point of information and referral (clients/caregivers/healthcare providers) providing active referrals, pulling services towards clients. BSO Connect is operated by the HNHB CCAC.
- BSO Community Outreach Team – five teams are located across the LHIN within existing community crisis teams providing 'just in time' (crisis) support to individual with or are at risk of developing responsive behaviours and linking them to longer term support.
- Integrated Community Lead (ICL) service model – where one community agency is the single point of contact for BSO clients. This model is being adopted by LHIN funded health service providers who provide care to the BSO population.
- BSO LTC Mobile Team- five teams have been implemented across the LHIN, serving the LHIN's 86 LTCHs.

Successes over the past year:

- All 86 of the HNHB LHIN Long Term Care Homes signed formal agreements enabling BSO staff to support their residents.
- 41 LHIN-funded community agencies identified as lead organizations for the BSO ICL service model.
- Implementation of the ICL service model across all five regions of the LHIN.
- As of March 31, 2013, the following programs reported:
    - BSO Connect served 459 individuals.
    - BSO Community Outreach Team served 701 clients, linking them with longer-term support as needed.
    - 41 LHIN funded agencies were operating as Integrated Community Leads (ICLs) for the BSO population across the LHIN.
    - 6,172 client-based services delivered to residents of LTC homes from October to March 31, 2013.[20]
- 917 referrals to the BSO LTC Model Team from October – December 2012.
- 320 clients benefited from navigational supports through the centralized referral process and the mobile community crisis worker linking the clients to services.
- Sustainability Plan developed though engagement with over 75 stakeholders including health care organization administrators, front line staff, family member representative and physicians.
- Developed 12 educational sessions (interactive and archived webcasts) sharing new models and real client success stories.

Wait Times Strategy

The Wait Times Strategy is continuing to increase its efforts to reduce wait times for access to care, particularly for cancer, cardiac, diagnostic imaging, joint replacement and cataract services for all residents of the LHIN.

The HNHB LHIN is fortunate to have individuals within our region with considerable expertise and knowledge in the interface between clinical practice, data management, and quality improvement. In 2012-13, the HNHB LHIN developed a Health System Funding Reform Local Partnership (HSFR-LP) and

[20] Program Reported Data March 31, 2013.

individuals from directly impacted hospitals and the CCAC have been asked to join the committee. Additional providers will be asked to participate in this initiative as HSFR implementation involves other sectors.

Ultimately, the HSFR–LP committee will provide advice and support to the LHIN for the strategic execution, change management, and implementation imperatives related to all aspects of health system funding reform. The purpose of this committee is to ensure a LHIN-wide understanding of key issues and their impacts across the health care continuum. The collaborative assessment of key opportunities and risks, and setting consensus based strategies will build capacity for the entire system as we move forward.

The HSFR-LP will provide advice for the following aspects of HSFR implementation:

- System change and operational alignment.
- Physician and staff engagement.
- Potential risks and mitigation strategies.
- Education and knowledge transfer.
- Methodology (technical issues, gaps).
- Data quality and availability.
- Communications.

In 2012-13 the LHIN's commitment to its residents was to provide timely access to quality services that involved evidence-based outcomes, active engagement and value for money.

While the LHIN did not see a reduction in wait times for total hip and knee replacement and cataract surgery in 2012-13, the LHIN did show significant improvements in wait times for diagnostic imaging and year-end wait times are improving for cancer and cardiac bypass surgery.

The LHIN continued to face challenges in 2012-13 that limited reported wait time reductions including:

- Increased demand due to the availability of inpatient beds. Inpatient beds are impacted by unplanned hospital demand and the inability to discharge an individual to post acute level of care.
- Data quality and variations. The LHIN is working with hospitals to ensure accurate data consistent with provincial standards. This includes data strategies such as use of Dates Affecting Readiness to Treat (DART) with LHIN hospital partners and physician groups for total joint replacements (TJRs) and cataracts.
- Inconsistent hospital practices for care paths which impacts patient flow. In 2012-13, the LHIN has worked with hospitals to standardize patient care paths for TJRs. In addition, St. Joseph's Healthcare Hamilton has been working on its Integrated Client Care Project (ICCP) as a strategy to address patient flow.

To improve access to health care and improve the quality of services in 2012-13 the LHIN, together with its health service providers across all sectors, undertook the following activities:

- Implemented hospital specific improvement strategies to reduce wait times, particularly in emergency departments and diagnostic imaging.
- Monitored wait time trends throughout the year to determine areas of need and implemented local and/or LHIN-based solutions, which included reallocating funding based on need.
- Provided stakeholders the education and information to monitor performance and support ongoing improvements.

- Facilitated joint discussion to identify inequities, reduce variations in service and support quality improvement plans both within and between hospitals to maximize volume capacity and improve patient flow.
- Worked closely with provincial programs to ensure optimal cancer and cardiac services every step of the way.

Performance Indicators

Performance Indicator	HNHB LHIN 12/13 Starting Point	HNHB LHIN 12/13 Performance Target	Most Recent Quarter 12/13	Percent from Target for Most Recent Quarter Result*	FY 2012/13 LHIN Annual Result
1. Percentage of Alternate Level of Care (ALC) Days – By LHIN of institution**	15.37%	11.00%	12.86%	16.9%	13.89%
• The HNHB LHIN demonstrated continual quarter over quarter improvement in the percentage of ALC days in 2012-13 going from 15.37% to 12.86%. • In 2011-12 the LHIN implemented a three year Action Plan that incorporated a bundled strategy approach to achieve sustainable improvement for this indicator. In 2012-13, the Patient Flow bundled strategy was expanded to include a Rapid Response Transitional Team (RRTT) that was implemented LHIN wide. This team assists seniors return home from hospital and facilitates a smooth transition. Also supports high risk seniors to remain in their home. • The LHIN's Patient Flow bundled strategy includes: a strong Home First philosophy, Intensive Case Management reviews for any individual experiencing less than 30 ALC days, restorative programs such as Assess Restore, Slow Stream Rehab and Convalescent Care, weekly monitoring, Early Intervention Screen for High Risk seniors in the emergency room and the RRTT program.					
2. 90th Percentile ER Length of Stay (LOS) for Admitted Patients	35.45	28.30	41.45	46.5%	35.63
• Admitted emergency room (ER) length of stay (LOS) continues to be one of the most challenging metrics for the LHIN to achieve sustainable improvement. In the first three months (April 1 – June 30, 2012) the LHIN saw a 3.15 hour improvement in this metric, however, in the next two quarters the LOS increased slightly to reach a high of 41.45 hours in the last quarter (January 1- March 31, 2013). The annualized result of the year was 35.63 hours, 7.33 hours above the target of 28.3 hours, a 26% variance from target. • The spike in September 2012 was largely attributed to longer wait times reported by two sites of the Niagara Health System (Greater Niagara General and Welland hospital sites) and Joseph Brant Hospital (JBH). In December 2012, and January 2013 LHIN hospitals reported 6,239 and 6,192 patients admitted through the ER. This represented an average of 417 additional patients admitted each month over the number admitted in November 2012 and the highest monthly volumes of admitted patients since ER LOS was reported in April 2008. This increase volume placed substantial pressure on hospitals as they opened beds to increase demand. • Factors influencing hospital ER wait times included: high numbers of admitted patients in the ER, infection control protocols, increasing high acuity and more complex cases with co-morbidities. • The LHIN meets monthly with hospitals with longer ER wait times to discuss strategies to improve performance. The LHIN is working with the LHIN's Emergency Services Steering Committee to develop a three year Action Plan to reduce ER admitted patient LOS.					
3. 90th Percentile ER LOS for Non-Admitted	7.75	7.50	7.82	4.3%	7.80

Complex (CTAS I-III) Patients					
• The LHIN's annual performance was 0.3 hours away from its actual target of 7.5 hours; it was however, within the 10% corridor for meeting the MLPA target. Over the past five years the LHIN has seen an increasing trend in the high acuity patient volumes (CTAS 1-3), which has contributed to LHIN hospitals achieving greater gains in this metric. • In 2012-13, LHIN's ERs treated 12,384 more high acuity cases representing a 4.7% increase over the preceding fiscal year. From 2008-09 to the end of 2012-13, the LHIN has seen a 30% increase, or approximately 63,713 more high acuity visits. • Despite the continued increasing volume trend, the overall LHIN ER LOS in this patient group is remaining fairly constant and remaining within the corridor. • The NHS – St. Catharines Site and the Welland Site are the two ERs struggling the most with performance in this area. LHIN staff are currently engaged in various activities with these two sites in order to improve their performance.					
4. 90th Percentile ER LOS for Non-Admitted Minor Uncomplicated (CTAS IV & V) Patients	4.87	4.50	4.87	8.2%	4.87
• The LHIN's annual performance was 0.37 hours away from its actual target of 4.5 hours; it was however, within the 10% corridor for meeting the MLPA target. • For the LHIN ER sites with greater than 30,000 annual visits (Pay-for-Results sites), this metric ranges from 3.2 to 7.4 hours. For non-P4R sites (<30,000 annual visits), the range is 1.7-7.1 hours. While there is less variability in the larger sites, the performance of the smaller sites tends to be better. Haldimand War Memorial Hospital is consistently the best performing site for this metric; of the Pay for Results sites, the NHS – Niagara Falls Site is generally the best performer for this metric. • Factors contributing to the wait times reported for individuals that are not admitted are: number of individuals waiting for an inpatient bed in the ER that require resources and stretcher space along with the time needed to complete medical tests (i.e. lab work, ultrasound). • LHIN hospitals have implemented Rapid Assessment Zones, Medical Directives, Physician See and • Treat areas, and Nurse Practitioners to improve the flow and reduce wait time for individuals that are of the non-admitted low acuity patient group.					
5. 90th Percentile Wait Times for Cancer Surgery	62	58	53	-8.62%	57
• In 2012-13, the HNHB LHIN exceeded its performance target for 90th percentile wait times for cancer surgery by one day. • The LHIN continues to monitor wait times with a focus on the Cancer Clinical Services Plan to support standardization and improve access for patients. The Cancer Clinical Services Plan has improved the regional organization of surgical oncology by disease. The establishment of satellite cancer services operating across the HNHB LHIN for systemic therapy has occurred as well as the deployment of a common oncology information system (MOSAIQ) across the LHIN. • A LHIN-wide Regional Cancer Scorecard, a component of the Cancer Clinical Services Plan, is in development with LHIN hospitals. This will enable monitoring common metrics including wait times.					
6. 90th Percentile Wait Times for Cardiac By-Pass Procedures	46	48	33	-31.25%	36

• In 2012-13, the HNHB LHIN exceeded its performance target for 90th percentile wait time for cardiac by-pass procedures by ten (10) days. This indicator only reports on the wait time for elective cardiac bypass surgery. • HHSC (General site) is the sole provider for cardiac surgery in the HNHB LHIN. In 2012-13, the LHIN had regularly monitored cardiac services to ensure that the 2012/13 targets were met.					
7. 90th Percentile Wait Times for Cataract Surgery	143	150	204	36.00%	189
• In 2012-13, the HNHB LHIN did not meet its performance target for 90th percentile wait time for cataract surgeries. The HNHB LHIN reviewed data at both the hospital and procedure group level to identify areas of standardization and improve access for patients. • Hospitals reported increased demand for this service. As such, additional HNHB LHIN funding was provided in winter 2012/13 to help address cataract surgery pressures. • Cataract volumes for the HNHB LHIN have been reduced by 12% over last year's actuals through the Quality-Based Procedure (QBP) allocation. This is having an impact on provision of cataract services and is having an impact on wait times. The LHIN has worked with hospitals providing cataract services to implement the new QBP funding formula including the identification and mitigation of the impacts upon volumes and other services. • The LHIN has worked with its hospital providers to develop more focused strategies for long wait cases and the utilization of wait-list management techniques such as Dates Affecting Readiness to Treat (DARTs).					
8. 90th Percentile Wait Times for Hip Replacement	229	182	274	50.55%	249
• In 2012-13, the HNHB LHIN did not meet its performance target for 90th percentile wait time for hip replacements and the 90th percentile wait time for knee replacements • The LHIN completed the Integrated Orthopaedic Capacity Plan (IOCP) in collaboration with hospitals and physicians and submitted this to the Ministry on March 31, 2013. The HNHB LHIN's work on the IOCP enabled for the implementation of the measures and practice changes required to meet the targets as outlined in the provincial Orthopaedic Scorecard. The group's focus included: Establishing a standardized process for patients from the time they enter the preoperative clinic until discharge from acute care; Establishing standardized care paths for patients who receive total joint replacements; Sharing best practices to improve length of stay and enable more seamless discharges. • The LHIN engaged surgeons on wait list management and decision support departments at hospitals to ensure proper coding practices. The LHIN also provided a comparison of LHIN and peer hospital data to Clinical VPs. This information allowed the LHIN implement orthopaedic related strategies and other opportunities for improvement in partnership of hospitals and the community (CCAC).					
9. 90th Percentile Wait Times for Knee Replacement	267	182	362	98.90%	331
• Please see above					
10. 90th Percentile Wait Times for Diagnostic MRI Scan	91	75	55	-26.67%	61

- In 2012-13, the HNHB LHIN exceeded its performance target for 90th percentile wait times for diagnostic MRI scan by 14 days.
- The hospitals report on a monthly basis to the LHIN on wait times and volumes for Priority 4 cases and teleconferences/meetings with individual hospitals occurred as needed. Weekly MRI dashboards were sent to the LHIN from each hospital to allow for close monitoring of their efficiency targets.
- The LHIN worked with different stakeholders (which will also include hospitals, physicians, etc.) to establish a LHIN-wide diagnostic imaging working group.

11. 90th Percentile Wait Times for Diagnostic CT Scans	45	41	39	-4.88%	38

- In 2012-13, the HNHB LHIN exceeded its performance target for 90th percentile wait times for diagnostic CT scans by 3 days.
- The LHIN has worked closely with all hospitals on monitoring the implementation of quality improvement plans and the sharing of best practices to ensure optimal outcomes. The HNHB LHIN continued to work with hospitals, DI Chiefs and working groups to maintain and improve these wait times. The DI Chiefs group identified priorities for 2012/13. These are: the completion and collection of the survey that has already been circulated regarding inventory of equipment, volumes and procedures related to CT and MRI; implementation of a common LHIN wide best practice of solitary pulmonary nodules and implementation of ACR-6 Choose Wisely, which is a document providing clear best practice and implementation standards.
- In November 2012, the DI Chiefs hosted a day focused on providing education to primary care physicians. This provided a foundation for an integrated quality process for patients in the HNHB LHIN.

12. Readmission within 30 Days for Selected CMGs* **	15.62%	14.50%	16.16%	11.45%	16.40%

- While the HNHB LHIN did not meet its performance target of 14.5% the LHIN did demonstrate continual quarter-to-quarter improvement in the percentage of patients readmitted for selected CMGs in 2012-13 going from 16.73 to 16.16. It is important to note that due to the availability of the data the percentage reported for 2012-13 actually reflects the twelve month period of October 1 2011 to September 30, 2012.
- The LHIN implemented a number of strategies to address appropriate admissions and readmissions to hospitals, these include:
    - The Early Intervention Screen for High Risk seniors as noted above. This tool screens individuals at risk for ER visits/hospitalizations. Individuals that meet the triggers of the tool are referred to the CCAC for new or enhanced services or information and referral to community services.
    - Implementation of the R2T2 program across the LHIN as noted under percent ALC day
    - Development of a Health Quality Ontario Discharge Transition Bundle.

13. Repeat Unplanned Emergency Visits within 30 Days for Mental Health Patients* **	19.93%	18.40%	18.04%	-1.96%	18.57%

- The LHIN has implemented a number of initiatives that has resulted in a reduced percentage of repeat unplanned emergency visits within 30 days for mental health patients in 2012-13:
    - A continued implementation of a centralized psychiatric sessional fee access model is

optimizing timely client access resulting in increased access to psychiatrist to underserved areas of the HNHB LHIN.

- Completed implementation of the Ontario Common Assessment of Need (OCAN) with mental health providers.
- The implementation of an Integrated Assessment Record (IAR) with In-Patient Mental Health hospitals is underway. This is allowing the sharing of assessments across a client's journey of recovery through the health care system between community and hospital.
- Crisis Outreach and Support Teams (COAST) are fully operational in Niagara and Hamilton with streamlining of services to include crisis services for children's mental health.
- Early Psychosis Intervention program expansion in Niagara and introduction of a new integrated program in Brant and Haldimand Norfolk counties thereby improving access in underserved areas of the HNHB LHIN.
- Implementation of the Mental Health Nurses in District School Boards.
- Ongoing work on building a continuum of crisis capacity both within the hospital ED and outside in the community; the addition of 3 social work positions to support local crisis models in Brant, Burlington and Niagara.
- OTN Nurses initiative is underway with the majority of nurses and nurse practitioner positions filled; this initiative will assist in improving access in underserved areas of the LHIN (Brant, Haldimand Norfolk and Niagara).
- Implementation of enhanced Specialized Geriatric Services program (interdisciplinary and multi-partner) in Haldimand-Norfolk and Niagara is completed and operating at full capacity.

14. Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Patients* **	22.40%	21.40%	20.42%	-4.58%	24.27%

- There are a high proportion of individuals with concurrent disorders (substance abuse and mental health issues) in the LHIN. Health service providers have identified this population as challenging to serve. Current research on concurrent disorders suggests that there is a high prevalence that individuals with a substance abuse problem will also have a mental health issue. As such, the LHIN has chosen not to separate these indicators and the strategies outlined focus on this dual approach.
- There are eight health service providers in the LHIN whose primary focus is persons with substance abuse conditions. The range of services includes residential treatment services, withdrawal management programs, problem gambling programs, assessment, treatment/counseling, education/health promotion, peer support and day programs.
- Although the LHIN did not achieve its year-end target for this metric, there has been a number of initiatives that have been implemented this year: to support clients with a substance abuse issue including:
  - Complex Care Resolution Tables are meeting regularly in Hamilton and Niagara and focus on frequent users of the hospital ED with addictions.
  - The close monitoring of OxyContin use by Addictions providers has served to inform planning of Addictions services in the HNHB LHIN. As a result, new investments of funding in underserviced areas of the LHIN focused on Supportive housing and intensive case management for people with problematic substance abuse.
  - Addictions supportive housing and case management.

15. 90th Percentile Wait Times for CCAC In-Home Services –	29	26	22	-15%	26

Application from Community Setting to first CCAC Service (excluding case management)**					
• In 2012-13, the HNHB LHIN met its performance target for 90th percentile wait time for this metric. • The LHIN continues to work closely with CCAC and Community Support Service agencies to ensure timely access to services in the home. The LHIN approved approximately $10 million in base funding for CCAC to support increased services.					

** A negative percentage means the LHIN is below its target*
*** FY 2012/13 is based on most recent four quarters of data (Q3 2010/11 - Q2 2011/12) due to availability*
**** FY 2011/12 is based on most recent four quarters of data (Q4 2010/11 - Q3 2011/12) due to availability*

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Independent Auditor's Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant
Local Health Integration Network

We have audited the accompanying financial statements of Hamilton Niagara Haldimand Brant Local Health Integration Network, which comprise the statements of financial position as at March 31, 2013, and the statements of financial activities, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Hamilton Niagara Haldimand Brant Local Health Integration Network, as at March 31, 2013 and the results of its financial activities, its change in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 29, 2013

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial position
as at March 31, 2013

	2013	2012
	$	$
Financial assets		
Cash	521,790	1,136,961
Accounts receivable - e-Health funding	-	200,000
Harmonized Sales Tax receivable	20,926	32,298
Accounts receivable - other	16,627	92,991
Due from MOHLTC to Health Service Providers ("HSPs") (Note 9)	11,936,000	5,292,440
	12,495,343	6,754,690
Liabilities		
Accounts payable and accrued liabilities	223,768	853,210
Due to the MOHLTC (Note 3b)	361,391	635,488
Due to HSPs from MOHLTC (Note 9)	11,936,000	5,292,440
Due to the LHIN Shared Services Office (Note 4)	9,196	-
Deferred capital contributions (Note 5)	19,088	155,301
	12,549,443	6,936,439
Net debt	(54,100)	(181,749)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	35,012	26,448
Tangible capital assets (Note 7)	19,088	155,301
Accumulated surplus	-	-

Approved by the Board

F. Lawlor
Director

Director

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial activities
year ended March 31, 2013

	Budget (Note 8)	2013 Actual	2012 Actual
	$	$	$
Revenue			
MOHLTC			
HSPs transfer payments (Note 9)	2,623,710,913	2,737,118,195	2,673,146,753
Operations of LHIN	4,916,172	4,916,172	5,174,872
Enabling Technologies (Note 10a)	580,000	580,000	600,000
ER/ALC Performance Lead (Note 10b)	100,000	100,000	100,000
French Language Services (Note 10c)	106,000	106,000	106,000
French Language Planning Entity (Note 10c)	411,693	411,693	411,693
Emergency Dept LHIN LEAD (Note 10d)	75,000	75,000	75,000
Critical Care LHIN LEAD (Note 10e)	75,000	75,000	75,000
Aboriginal Planning (Note 10g)	37,500	37,500	37,500
Behavioural Support Ontario (Note 10h)	-	-	750,000
Primary Care LHIN Lead (Note 10f)	75,000	75,000	43,750
Diabetes Education (Note 10i)	140,396	140,396	-
Amortization of deferred capital contributions (Note 5)	147,759	153,534	156,666
	2,630,375,433	2,743,788,490	2,680,677,234
Funding repayable to the MOHLTC (Note 3a)	-	(328,956)	(747,488)
	2,630,375,433	2,743,459,534	2,679,929,746
Expenses			
Transfer payments to HSPs (Note 9)	2,623,710,913	2,737,118,195	2,673,146,753
General and administrative (Note 11)	5,063,931	4,803,000	5,219,538
Enabling Technologies (Note 10a)	580,000	580,000	600,000
ER/ALC Performance Lead (Note 10b)	100,000	100,000	100,000
French Language Services (Note 10c)	106,000	101,432	106,000
French Language Planning Entity (Note 10c)	411,693	446,113	151,822
Emergency Dept LHIN LEAD (Note 10d)	75,000	75,000	73,900
Critical Care LHIN LEAD (Note 10e)	75,000	73,025	73,896
Aboriginal Planning (Note 10g)	37,500	37,500	37,500
Behavioural Support Ontario (Note 10h)	-	-	407,837
Primary Care LHIN Lead (Note 10f)	75,000	68,750	12,500
Diabetes Education (Note 10i)	140,396	56,519	-
	2,630,375,433	2,743,459,534	2,679,929,746
Annual surplus and accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of change in net debt
year ended March 31, 2013

	Budget (Note 8)	2013 Actual	2012 Actual
	$	$	$
Annual surplus	-	-	-
Prepaid expenses, net	-	(8,564)	(13,074)
Acquisition of tangible capital assets	-	(17,321)	-
Amortization of tangible capital assets	147,759	153,534	156,666
Decrease in net debt	-	127,649	143,592
Net debt, beginning of year	-	(181,749)	(325,341)
Net debt, end of year	-	(54,100)	(181,749)

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of cash flows
year ended March 31, 2013

	2013	2012
	$	$
Operating transactions		
Annual surplus	-	-
Add items not affecting cash		
Amortization of tangible capital assets	153,534	156,666
Less items not affecting cash		
Amortization of deferred capital contributions (Note 5)	(153,534)	(156,666)
Changes in non-cash operating items		
Decrease (increase) in accounts receivable - other	76,364	(92,991)
Decrease (increase) in accounts receivable - e-Health funding	200,000	(200,000)
Decrease in HST receivable	11,372	17,498
(Increase) decrease in due from MOHLTC to HSPs	(6,643,560)	6,046,273
Decrease in accounts payable and accrued liabilities	(629,442)	(223,820)
Decrease in due to the MOHLTC	(274,097)	(215,709)
Increase (decrease) in due to HSPs from MOHLTC	6,643,560	(6,046,273)
Increase (decrease) in due to the LHIN Shared Services Office	9,196	(4,089)
Increase in prepaid expenses	(8,564)	(13,074)
	(615,171)	(732,185)
Investing transaction		
Acquisition of tangible capital assets	(17,321)	-
Financing transaction		
Capital contributions received (Note 5)	17,321	-
Net change in cash	(615,171)	(732,185)
Cash, beginning of year	1,136,961	1,869,146
Cash, end of year	521,790	1,136,961

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Notes to the financial statements
March 31, 2013

1. Description of business

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry – LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC"). These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2013.

The LHIN has also entered into an Accountability Agreement with the MOHLTC, which provides the framework for LHIN accountabilities and activities.

The LHIN statements do not include any MOHTLC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian Public Sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital asset and impairment in the value of assets.

2. **Significant accounting policies (continued)**

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

2. Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Adoption of new accounting standards

As at April 1, 2012, the LHIN adopted Public Sector Accounting Handbook *Section PS 1201, "Financial Statement Presentation"*, Section PS 2601 *"Foreign Currency Translation"*, PS 3410 *"Government Transfers"* and Section PS 3450, *"Financial Instruments"*. There was no impact of the adoption of these new standards on the financial statements.

3. Funding repayable to the MOHLTC

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

			2013	2012
	Funding Received	Eligible Expenses	Excess Funding	Excess Funding
	$	$	$	$
Transfer payments to HSPs	2,737,118,195	2,737,118,195	-	-
LHIN operations	5,069,706	4,803,000	266,706	112,000
Behavioural Supports Ontario ("BSO")	-	-	-	342,163
LHIN ETI	580,000	580,000	-	-
French Language Planning Entity	411,693	446,113	(34,420)	259,871
French Language Services	106,000	101,432	4,568	-
ER/ALC Performance Lead	100,000	100,000	-	-
Emergency Dept. LHIN LEAD	75,000	75,000	-	1,100
Critical Care LHIN LEAD	75,000	73,025	1,975	1,104
Primary Care Lead	75,000	68,750	6,250	31,250
Aboriginal Planning	37,500	37,500	-	-
Diabetes Education	140,396	56,519	83,877	-
	2,743,788,490	2,743,459,534	328,956	747,488

3. **Funding repayable to the MOHLTC (continued)**

b) The amount due to the MOHLTC at March 31, 2013 is made up as follows:

	2013	2012
	$	$
Due to MOHLTC, beginning of year	635,488	851,197
Prior Year BSO funds not spent	32,435	-
Funding repayable related to current year activities to the MOHLTC (Note 3a)	328,956	747,488
Amount recovered by the MOHLTC during the year	(635,488)	(963,197)
Due to MOHLTC, end of year	361,391	635,488

4. **Related party transactions**

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end, are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all LHINs.

5. **Deferred capital contributions**

	2013	2012
	$	$
Balance, beginning of year	155,301	311,967
Capital contributions recevied during the year (Note 10i)	17,321	-
Amortization for the year	(153,534)	(156,666)
Balance, end of year	19,088	155,301

6. **Commitments**

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years and thereafter are as follows:

	$
2014	163,313
2015	172,786
2016	172,786
2017	172,786
2018	172,786
Thereafter	120,383

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon LHIN funding received from MOHLTC.

7. Tangible capital assets

	Cost	Accumulated amortization	2013 Net book value	2012 Net book value
	$	$	$	$
Office equipment, furniture and fixtures	129,581	129,581	-	-
Computer equipment	488,759	470,770	17,989	39,713
Leasehold improvements	572,444	571,345	1,099	115,588
	1,190,784	1,171,696	19,088	155,301

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of financial activities reflect the initial budget at April 1, 2012. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,737,118,195 is derived as follows:

	$
Initial budget	2,623,710,913
Adjustment due to announcements made during the year	113,407,282
Final budget	2,737,118,195

The final LHIN general and administrative budget of $6,516,761 is derived as follows:

	$
Initial budget	
LHIN operations	4,916,172
LHIN ETI	580,000
Aboriginal Planning	37,500
Additional funding received during the year for:	
French Language Planning Entity	411,693
French Language Services Coordinator	106,000
ER/ALC Performance Lead	100,000
Emergency Dept. LHIN LEAD	75,000
Critical Care LHIN LEAD	75,000
Primary Care Lead	75,000
Diabetes Education	140,396
Final budget	6,516,761

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,737,118,195 (2012 - $2,673,146,753) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2013 as follows:

	2013	2012
	$	$
Operation of hospitals	1,850,871,086	1,815,165,386
Grants to compensate for municipal taxation - public hospitals	464,025	458,100
Long term care homes	441,245,153	434,978,512
Community care access centres	272,408,894	259,534,247
Community support services	42,928,049	42,481,395
Acquired brain injury	6,654,450	6,612,526
Assisted living services in supportive housing	28,557,365	25,735,425
Community health centres	23,311,898	23,113,795
Community mental health addictions program	70,677,275	65,067,367
	2,737,118,195	2,673,146,753

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As of March 31, 2013 an amount of $11,936,000 (2012 - $5,292,440) was payable to the HSPs. This amount has been reflected as revenue and expenses within the LHIN's financial activities and is included above.

10. Other funding initiatives

a) *LHIN Enabling Technologies for Integration (LHIN ETI) Project Management Office*

During fiscal 2013, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $580,000 (2012 - $600,000). $580,000 of these funds were used toward initiatives in support of the Project Management Office for 2013 update of the E-Health strategic plan.

b) *ER/ALC Performance Lead*

During fiscal 2013, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $100,000 (2012 - $100,000). These funds were used to support the activities of the ER/ALC Coordinator.

c) *French Language Services*

During fiscal 2013, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $517,693 (2012 - $517,693). Of this amount, $106,000 was used to support the French Language Services Coordinator role (2012 - $106,000) and $446,113 was included in the initial allocation for the French Language Planning Entity (2012 - $151,822).

10. Other funding initiatives (continued)

d) Emergency Department LHIN LEAD

During fiscal 2013, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2012 - $75,000). These funds were used toward initiatives in support of Emergency Department LHIN LEAD activities.

e) Critical Care LHIN LEAD

During fiscal 2013, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of 75,000 (2012 - $75,000). These funds were used toward initiatives in support of Critical Care LHIN LEAD activities.

f) Primary Care LHIN LEAD

During fiscal 2013, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2012 - $43,750). These funds were used toward initiatives in support of Primary Care LHIN LEAD activities.

g) Aboriginal Planning

During fiscal 2013, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $37,500 (2012 - $37,500). These funds were used to support Aboriginal Planning activities.

h) Behavioural Supports Ontario (BSO) Initiative

In 2012 the Ministry of Health and Long-Term Care provided one time funds of $750,000 to the LHIN to support the successful implementation of the local action plan for the BSO project under our transfer payments to our HSPs. The BSO project was created to enhance services for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions wherever they live, at home, in long-term care or elsewhere. There was no funding for BSO allocated to the LHIN for 2013.

i) Diabetes Education

In February 2013 the Ministry of Health and Long Term Care provided an initial allocation of $157,717 to the LHIN as a transfer of funding to be used to oversee Diabetes Education in the LHIN. There are several Diabetes Education teams in the LHIN and the responsibility for these teams has been transferred to the LHIN. This is not new funding, but a reallocation from the organization who previously had this responsibility. Staff has been hired to ensure that the LHIN can improve the Diabetes outcomes. Annualized funding will be received in 2014. Computers and furniture has been purchased for these new staff. From the initial allocation of $157,717, $17,321 of tangible capital assets had been purchased and is reflected in the statement of financial position.

11. Expenses by object

The Statement of financial activities presents the expenses by function. The following classifies general and administrative expenses by object:

	2013	2012
	$	$
Salaries and benefits	3,325,055	3,727,382
Board Chair per diems	18,239	20,650
Directors' per diems	33,956	62,200
Board expenses	6,159	17,994
Travel	32,734	36,470
Consulting services	281,905	200,057
Community forums and communication	65,795	47,418
Supplies, equipment, maintenance, other	71,788	84,816
Occupancy costs	296,355	363,890
Amortization	153,534	156,666
Shared services	517,480	501,995
General and administrative expenses	4,803,000	5,219,538
Salaries and benefits	260,207	401,632
Travel	5,063	14,925
Contracted Services	1,251,312	1,090,144
Community forums and communication	19,682	43,738
Supplies, equipment, maintenance, other	385	13,016
Shared services	1,690	-
Other funding initiatives expenses	1,538,339	1,563,455
	6,341,339	6,782,993

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 35 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2013 was $276,088 (2012 - $293,761) for current service costs and is included as an expense in the Statement of financial activities. The last actuarial valuation was completed for the plan as at December 31, 2012. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

14. Comparative figures

Certain comparative numbers have been changed to conform to the current year presentation.

Board Members

(as of March 31, 2013)

Michael P. Shea
Chair

Bob Lawler
Vice Chair

Ruby Jacobs
Board Member

Helen Mulligan
Board Member

Laurie Ryan-Hill
Board Member

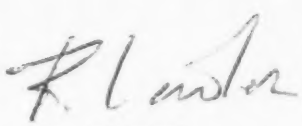
Mervin Witter
Board Member

Senior Staff Member

Donna Cripps
Chief Executive Officer

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2013.

Michael P. Shea
Chair, Board of Directors



Bob Lawler
Vice Chair, Board of Directors

Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

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